Telix

Capital Markets Day

November 4, 2026
Melbourne, Australia

ASX: TLX | NASDAQ: TLX



Radiopharmaceutical manufacturing suite at TMS North Melbourne.

Forward looking statement

This presentation should be read together with our risk factors, as disclosed in our most recently filed reports with the Australian Securities Exchange (ASX), U.S. Securities and Exchange Commission (SEC), including our Annual Report on Form 20-F filed with the SEC, or on our website.

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Telix’s first generation PSMA-PET imaging product, gallium-68 (^{68}Ga) gozetotide injection (also known as ^{68}Ga PSMA-11 and marketed under the brand name Illuccix®), has been approved in multiple markets globally. Gozellix® (kit for the preparation of gallium-68 (^{68}Ga) gozetotide injection) has been approved by the U.S. Food and Drug Administration (FDA). Telix’s glioma imaging agent, floretyrosine F 18, marketed under the brand name Pixclara®, is also approved by the FDA. Telix’s osteomyelitis (bone infection) imaging agent, technetium-99m (^{99m}Tc) besilesomab (marketed under the brand name Scintimun®) is approved in 32 European countries and Mexico. Telix’s miniaturized surgical gamma probe, SENSEI®, for minimally invasive and robotic-assisted surgery, is registered with the FDA for use in the U.S. and has attained a Conformité Européenne (CE) Mark for use in the EEA. Registrations vary country to country. Refer to your local approved label or regulatory authority status for full information.

No other Telix drug or device has received marketing authorization in any jurisdiction. Any other Telix drug or device that is discussed in this presentation, including Zircaix and Pixlumi, is investigational or under development and not approved by any regulatory authority. The efficacy or safety profile of any unapproved drug or device has not been determined by any regulatory authority. In addition, Zircaix and Pixlumi brand names and launch are subject to final regulatory approval.

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Telix management



Dr. Christian Behrenbruch

Managing Director and Group CEO



Mr. Darren Smith

Group Chief Financial Officer



Dr. David N. Cade, MD

Group Chief Medical Officer

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Key Opinion Leaders



Prof. Munir Ghesani

Nuclear Medicine Physician, Professor of Radiology Icahn School of Medicine Mount Sinai and Chief Medical Officer at United Theranostics, USA



Dr. Philip Dundee

Urological Surgeon, Director Robotic Surgery Fellowship Program, Royal Melbourne Hospital, Australia



Prof. Louise Emmett

Director of Theranostics and Nuclear Medicine St Vincent's Hospital, Sydney, Australia



Prof. Andrew Scott

Professor of Medicine, University of Melbourne, La Trobe University, Head of Tumour Targeting Laboratory Olivia Newton-John Cancer Research Institute, Australia

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Views expressed are speakers' own. Any presenter's response during Q&A has not been reviewed in advance by Telix.

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Strategy & overview

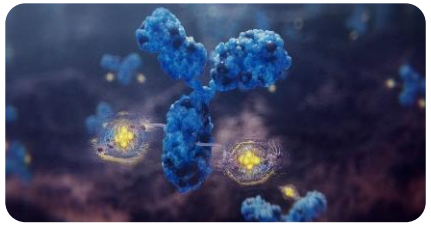
Dr. Christian Behrenbruch
Managing Director
and Group CEO



Telix at a glance

A diversified, vertically integrated radiopharma company

Integrated theranostic approach: See It. Treat It.



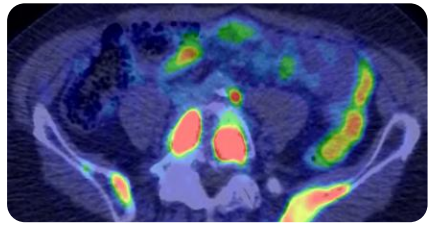
Precision Medicine portfolio



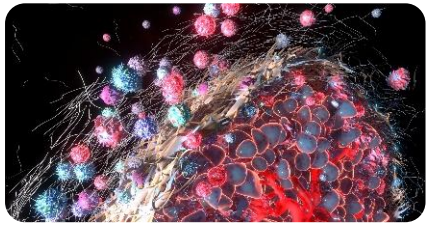
Specialist commercial organization



Vertically integrated manufacturing and supply



High-value therapeutics pipeline



R&D platform for new molecular entities

3

FDA-approved products

Illuccix® Gozellix® Pixclara®

22

countries

Illuccix® commercially available

45

manufacturing and

distribution sites globally

US$950M-$970M

(AUD $1.36-1.39B)

revenue guidance

FY2026[1]

Our purpose: We help people with cancer and rare diseases live longer, better quality lives

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As of October 30, 2026.

1. ASX release October 21, 2026.

Radiopharmaceuticals: a rapidly expanding market

CAGR (10yr):

26%

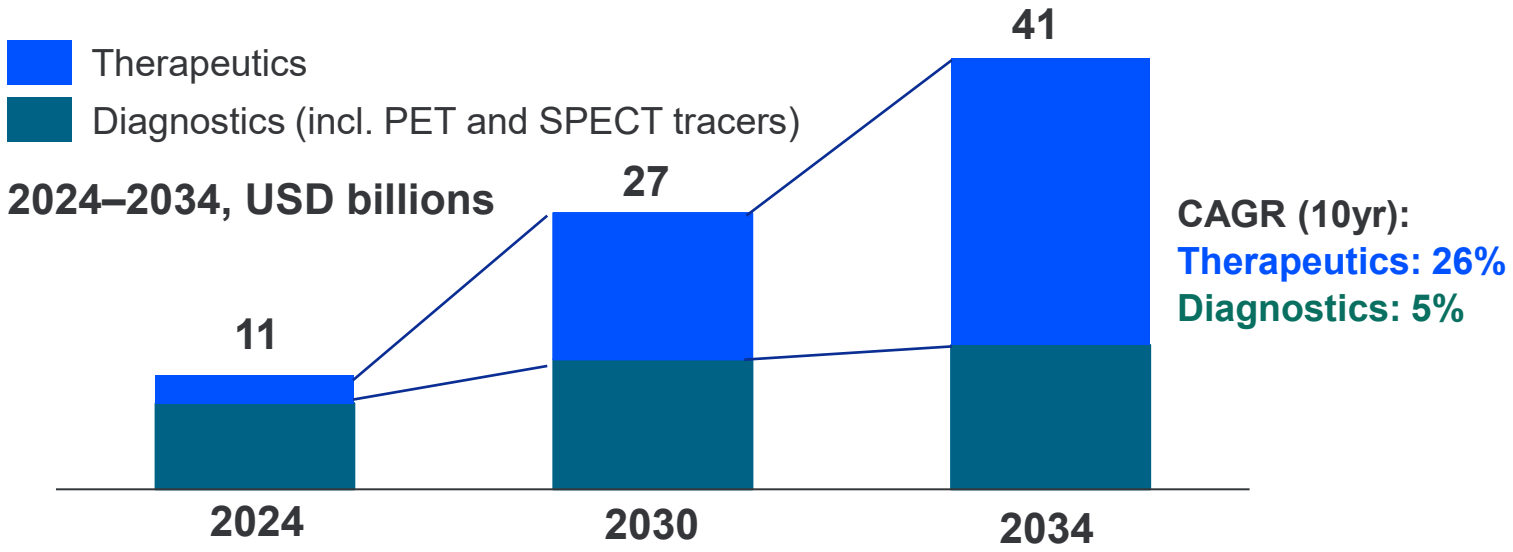
Therapeutics

~US$3B
2024

→

~US$27B
2034

Global nuclear medicine market growth



Over 100 therapeutic targets under investigation[1]

41 Lu-177 candidates
34 Ac-225 candidates
25 Pb-212 candidates
16 At-211 candidates

~50 radiopharmaceutical companies with a focus on therapeutics[2]

Continued global demand for imaging agents

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Source: MEDraysIntell 2025 Nuclear Medicine Report. Industry forecasts, not Telix guidance.
Notes: Diagnostics includes SPECT tracers (including 111In, 123I and 201Tl), PET includes 68Ga generators.
1. Exhibit 16, William Blair: Radiopharmaceuticals- 5th Edition.
2. Exhibit 11, William Blair: Radiopharmaceuticals- 5th Edition.

Three growth engines creating long-term value

Commercial expansion, novel therapies and integrated supply underpin our growth strategy

1

Scaled commercial business

Extend market-leading precision medicine commercial position through product innovation, diversification and global expansion.

2

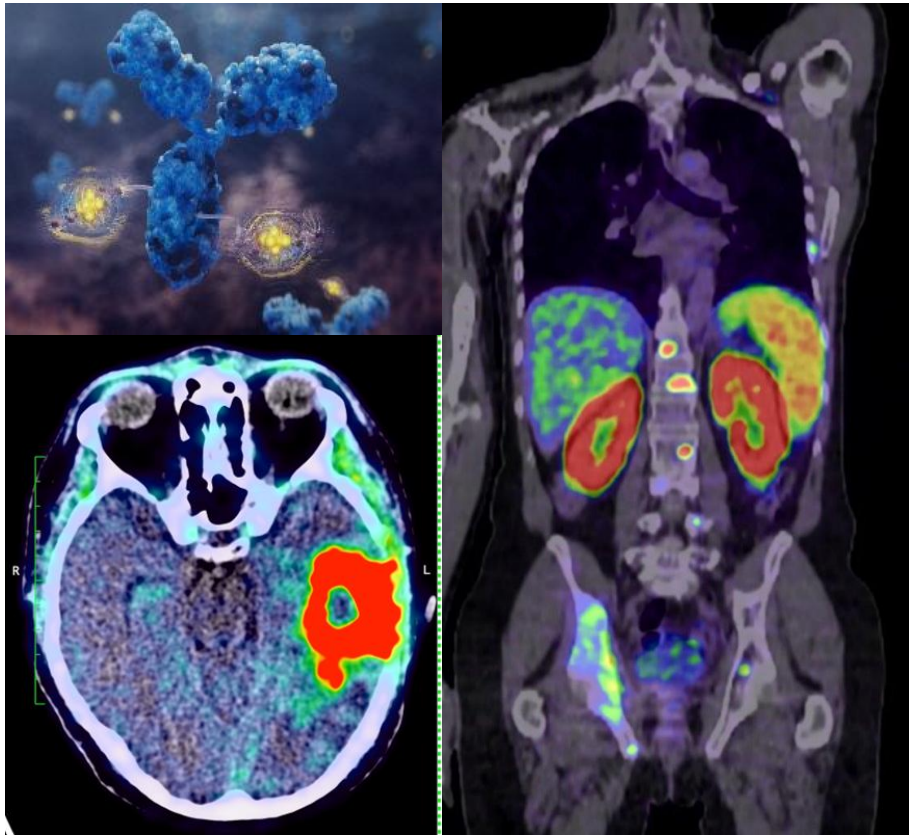
Therapeutic and precision medicine pipeline

Advance multiple products and therapies to market, expanding patient access to transformative diagnostics and therapeutics.

3

Best-in-class manufacturing & supply

Expand vertically integrated global supply chain to enhance capacity, control and scalability.



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Three FDA approved precision medicine products fuel our commercial engine

FDA APPROVED

illuccix®
(kit for the preparation of gallium Ga 68 gozetotide Injection)

- Clinical differentiation, proven track record, year over year volume growth
- Launched in **22 countries**[1]
- NDA under review by NMPA in **China**[2]
- Registration enabling study completed enrollment in **Japan**[3]

FDA APPROVED



FDA APPROVED

Pixclara®
(floretyrosine F 18)

- First FDA-approved FET-PET imaging drug for glioma[4]
- Included in National Comprehensive Cancer Network **(NCCN®) guidelines**
- Inclusion in **International guidelines:** EANM/EANO/RANO/SNMMI

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NDA = New Drug Application. NMPA = National Medical Products Administration.

1. Telix ASX disclosure April 6, 2026.
2. Telix ASX disclosure January 20, 2026.
3. Telix media release July 17, 2026. Japan Registry of Clinical Trials identifier: JRCT2031250473.
4. Telix ASX disclosure September 14, 2026.

Expanding addressable market for our commercial business and near-term commercial products

	Commercial Products		Near-Commercial		
Product	**Illuccix/Gozellix** **Diagnostic** Prostate cancer	**Pixclara** **Diagnostic** Brain cancer (Glioma)	**Zircaix** **Diagnostic** Kidney cancer	**BiPASS** **Diagnostic** Prostate cancer (Pre-Biopsy)	**ITM-11**[1] **Therapeutic** Neuroendocrine tumors (GEP-NETs)
U.S. TAM Scans / patients $	**~670,000 scans** **~$2.7B**	**~21,200 scans** **~$106M** ↓ **~$300M+**[2]	**~116,320 scans** **~$600M**	**~821,000 scans** **~$3.3B**	**~13,800 patients** **~$1.7B**

illuccix® (kit for the preparation of gallium Ga 68 gozetotide Injection)

Gozellix kit for the preparation of gallium Ga 68 gozetotide injection

Pixclara (floretyrosine F 18)

Zircaix (zirconium Zr 89 girentuximab senvedoxam-crdi)

BiPASS

itm PASSION FOR PRECISION

Potential to add three-high value commercial products in 2027

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Source: Datamonitor, Clarivate, internal estimates. Total Addressable Market (TAM) for Precision Medicine uses $4,000/scan for modelling purposes. Therapeutics candidates are using $250,000/treatment based on commercial benchmarks/Datamonitor. These price points do not reflect the actual price charged or the price that Telix will charge in the future. Intended for investor audience only. The FDA has approved Illuccix for use in initial staging, BCR, and RLT selection. The FDA has approved Gozellix for use in initial staging and BCR. Not intended to advertise or promote any other product or indication. BiPASS has not been accepted by the FDA to diagnose, treat, cure, or prevent any disease. Brand names subject to regulatory approval.

1. This asset is included subject to closing of the ITM transaction, which remains subject to Telix Shareholder approval, regulatory approvals and other customary closing conditions.
2. Potential for baseline FET PET scanning.

Late-stage therapeutic pipeline transformational to Telix's growth

Late-stage therapeutics	U.S. TAM	Status	Upcoming milestones
TLX591-Tx Prostate cancer (mAPMR)	**~$5.6B** ~22,460 Patients	**Phase 3**	**Interim futility analysis**
TLX597-Tx Prostate cancer (mAPMN/S)	**~$4.2B** ~16,800 Patients	**Phase 2**	**Optimal-PSMA data readout**
TLX101-Tx Brain cancer (Glioblastoma)	**~$1.2B** ~8,100 Patients	**Phase 3**	**Enrollment progression**
TLX250-Tx Kidney cancer	**~$1.1B** ~4,700 Patients	**Phase 2/3**	**Enrollment progression**

Transformational therapeutic opportunities
Higher-margin product launches

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TAM Source: Datamonitor, Clarivate, internal estimates. Total Addressable Market (TAM) for Precision Medicine uses $4,000/scan for modelling purposes. Therapeutics candidates are using $250,000/treatment based on commercial benchmarks/Datamonitor. These price points do not reflect the actual price charged or the price that Telix will charge in the future.

Vertically integrated manufacturing drives scale and value

Supply-chain control matters in a sector defined by time-critical delivery, specialist infrastructure, complex regulation and limited suppliers

Supply security

Less reliance on third parties

Greater ability to build redundancy.

Speed

More streamlined technology transfer between discovery, development and manufacturing.

Economics

COGS advantage and process optimization.

Efficient dose calibration and lower distribution costs.

Scalability

Seamless transition from development to commercial operations.

Isotope and cGMP infrastructure for clinical and commercial scale-up.

Risk mitigation

Reduced regulatory risk and a seamless CMC package.

Lower exposure to third-party quality and reliability risks.

Faster innovation

Closer collaboration across isotope scientists, radiochemists, biologists and chemists.

Refined processes to move discoveries toward clinical use.

From secure supply to timely and reliable patient access

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Specialized radiopharma supply chain

Building in-house capabilities across critical stages of the value chain

Radioisotope supply

Isotopes › Irradiation and purification

Targeting molecules

Antibody or small molecule › Chelator conjugate › Cold kit Non-radioactive



Radiolabelled drug product

Radioactive product

Unit dose

Quality control and release

Last-mile delivery

Distribution to point of care

Telix capabilities

ARTMS A Telix Company
- Isotope production

IsoTherapeutics A Telix Company
- Bioconjugation / isotope processing

Telix Manufacturing Solutions
- **Seneffe:** GMP manufacturing, QC, secondary packaging
- **Yokohama:** Clinical manufacturing
- **Sacramento:** Clinical doses/ process development
- **North Melbourne:** Hotlab, dosimetry

RLS Radiopharmacies A Telix Company
- Radiolabelling, dispensing, distribution network

+ **itm**[1] PASSION FOR PRECISION
- Isotope manufacturing and distribution network

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1. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

In-house radioisotope production capabilities

Supports current commercial and late-stage portfolio, plus next generation therapeutics

ARTMS – QIS® Technology



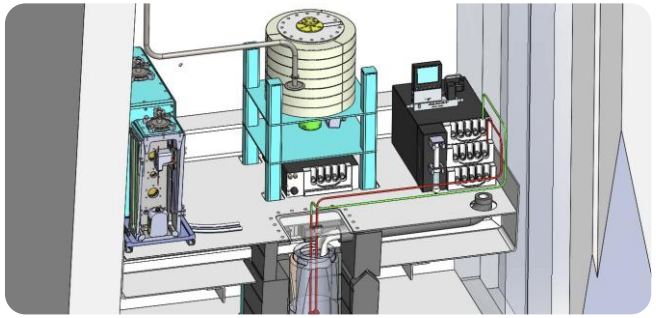
- Radiometal production technology deployed on all Telix Group cyclotrons and global partner network
- Large scale regional 68Ga production supporting future 68Ga-PSMA-11 demand including BiPASS
- High volume 89Zr production ready for Zircaix commercial launch

ITM[1] – Global leader in Lu-177



- World leader in 177Lu production for quality and scalability
- Capacity to supply commercial scale TLX591-Tx, TLX597-Tx, TLX250-Tx, ITM-11, or any other 177Lu therapy
- Largest stockpile of starting material and most secure irradiation sources in the industry

Control over next generation alphas

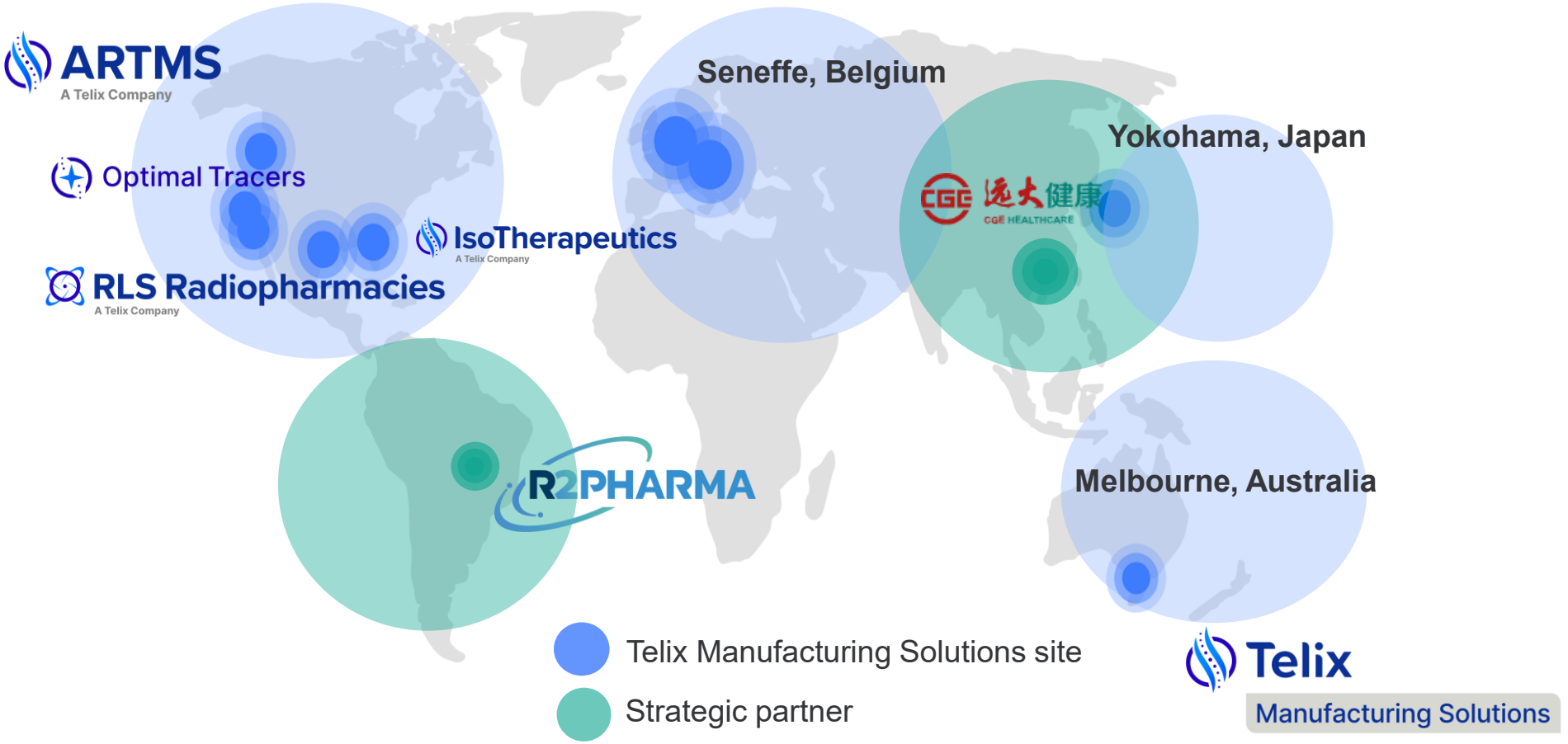


- Validated Telix 212Pb generator, with potential to scale to commercial levels
- Partnership with IBA/Framatome (Ekalia) for 211At in U.S.
- 225Ac internal production technology through ITM x Actineer JV and co-development agreement with EZAG

1. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

Scaled globally, positioned for long-term value

Global manufacturing and supply chain footprint



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Transaction reinforces Telix's growth strategy

The combination of ITM + Telix enhances our ability to compete

Telix + itm[1] PASSION FOR PRECISION

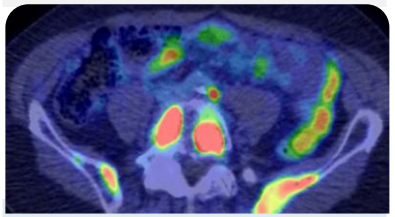
Vertically integrated manufacturing / supply chain



Value creation from therapeutic radioisotopes leadership

✓

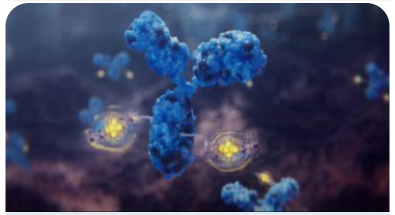
High value therapeutics pipeline



Accelerates entry into therapeutic commercial infrastructure & supply chain

✓

Precision Medicine portfolio



Novel product and life-cycle management opportunities

✓

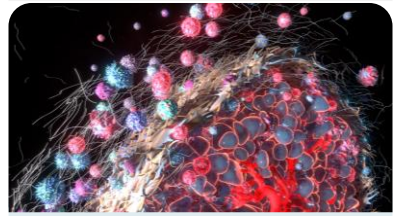
Specialist commercial organization



Adds commercial depth and expertise

✓

R&D platform for new molecular entities



Enhanced development capabilities

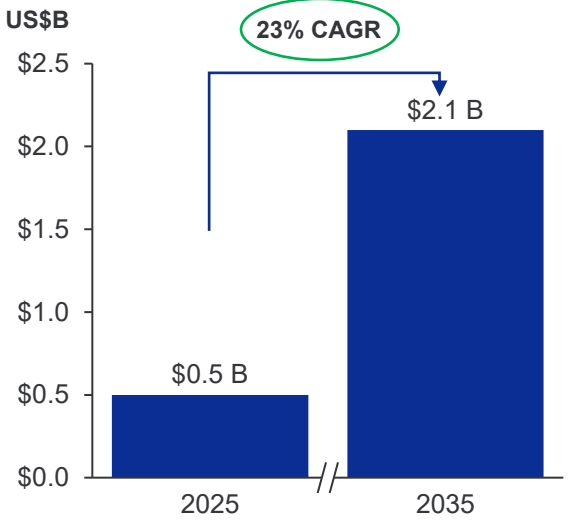
✓

1. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

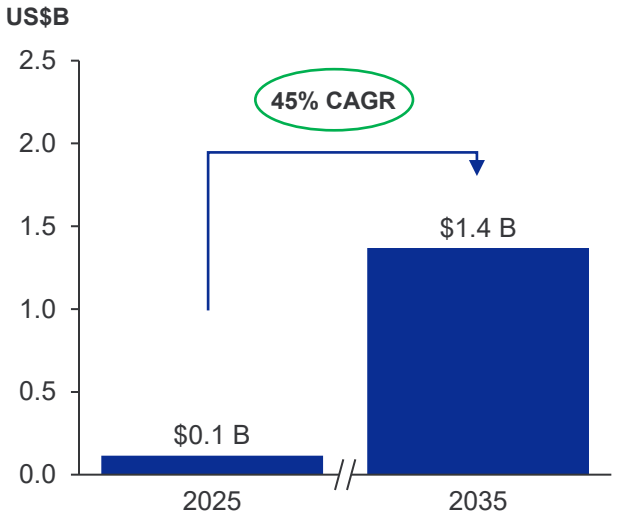
Telix + ITM positioned to service growing commercial and clinical demand

Radioisotope markets forecast to compound at ~30% p.a. through 2035[1]

^{177}Lu total market (US$B)[1]
Growth to $2.1B risk adjusted by 2035



^{225}Ac total market (US$B)[1]
Growth to $1.4B risk adjusted by 2035



INDUSTRY ASSETS IN DEVELOPMENT[2]

^{177}Lu

41

assets in development

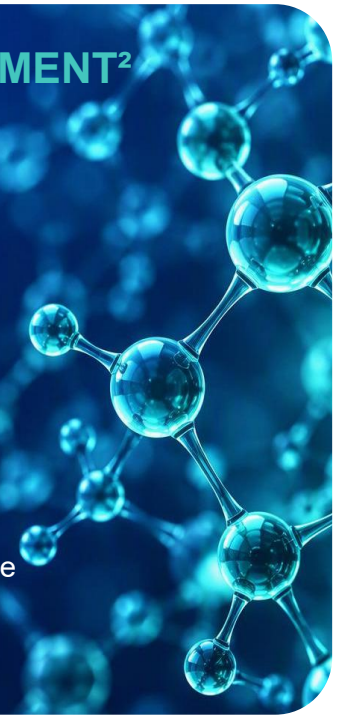
Plus two therapies at commercial stage

^{225}Ac

34

assets in development

Second most-used isotope in trials, behind ^{177}Lu



Security of supply increasingly valuable as more assets progress to commercialization

Industry forecasts are not Telix guidance. Development-asset counts are industry-wide, not Telix's pipeline.
1. Advancy research & analysis, Commercial Vendor Due Diligence, February 2026. 2. William Blair Equity Research 2026.
The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

Building a radiopharmaceutical powerhouse

Positioned for leadership in a fast-growing segment of oncology

Why invest now?

Secure supply and protect launches

- Ensures Telix has the critical infrastructure, supply and capacity to meet demand for commercial products.

Attract world-class talent

- An integrated R&D, manufacturing and commercial platform positions Telix to attract and retain specialist talent.

Partner of choice for the next generation

- R&D focused on novel and next-generation targets positions Telix as a strategic partner of choice for big pharma, academic researchers and other innovators.

Capability	Big pharma Consolidated	Specialty radiopharma Consolidated	Telix + ITM
Therapeutic: Lutetium	✓	✓	✓
Therapeutic: Actinium	✓	✗	✓
Therapeutic: Terbium	✗	✗	✓
Therapeutic: Iodine	✗	✗	✓
Targeting modality: Peptide	✓	✓	✓
Targeting modality: Antibody	✓	✗	✓
Targeting modality: Small molecule	✓	✓	✓
Commercial diagnostics	✓	✓	✓
Isotope supply: Lutetium	✗	✓	✓
Isotope supply: Actinium	✓	✗	✓

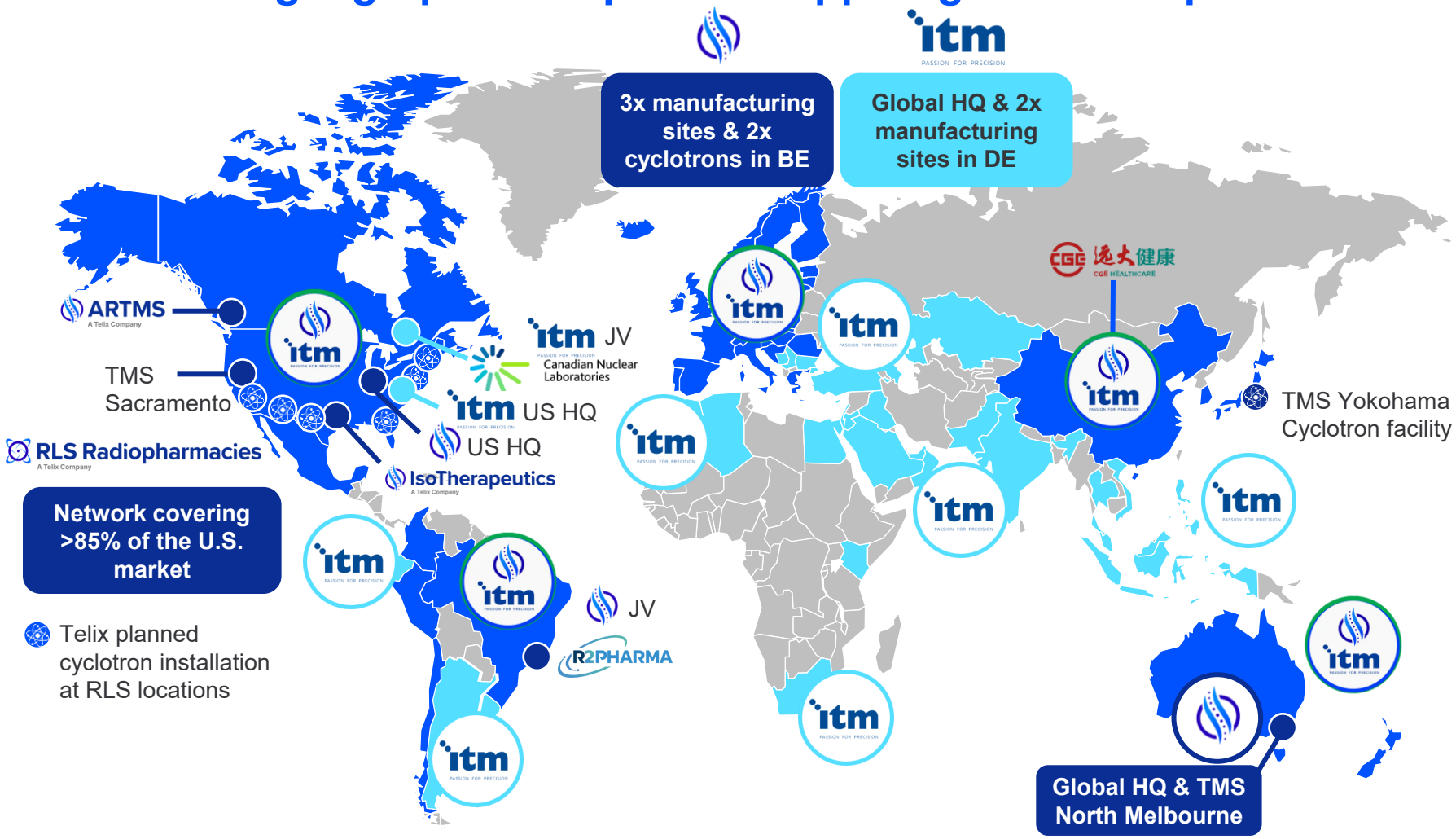
Source: Public filings, Wall Street research, clinicaltrials.gov, FactSet, and ITM Management as of October 2026.

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The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

Creating a fully integrated global radiopharma leader

Strong foundation and geographic footprint to support global therapeutic launches



The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

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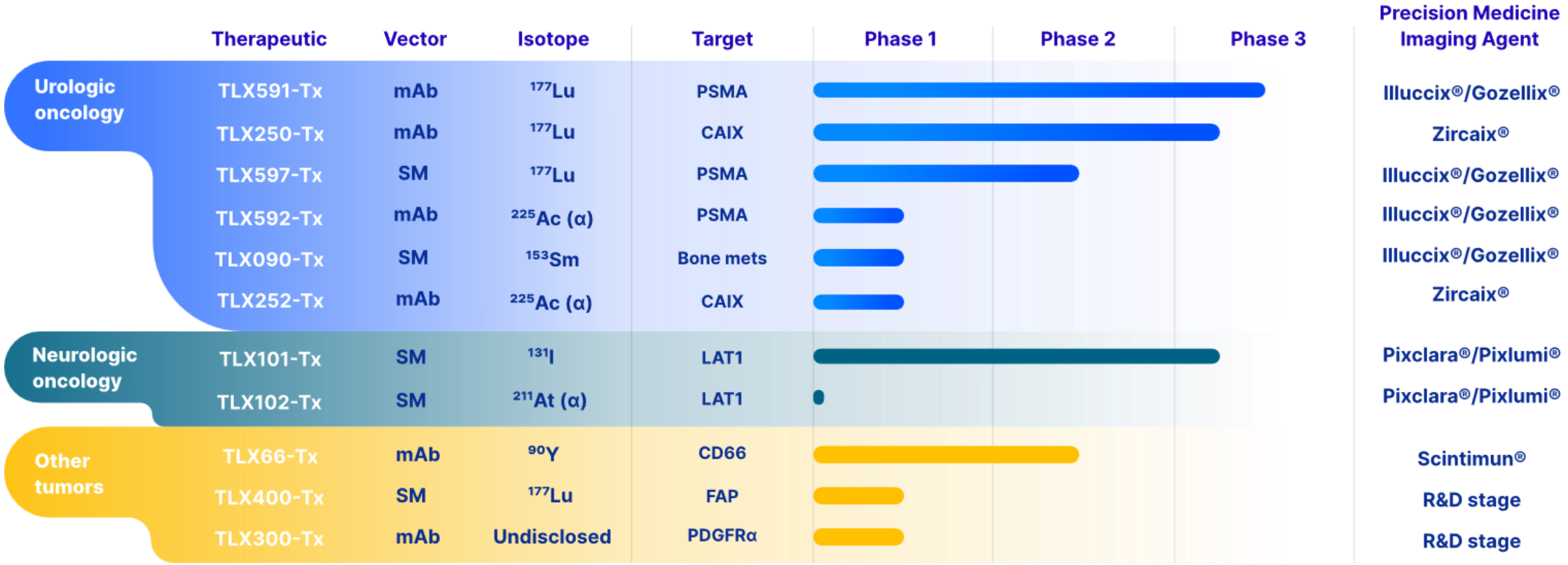
Pipeline

Dr. David N. Cade

Group Chief Medical Officer



Late-stage and “next generation” therapeutic assets



Pixlumi, Zircaix brand names subject to regulatory approval.

PSMA: Prostate-specific membrane antigen.
CAIX: Carbonic anhydrase IX.
LAT1: L-Type amino acid transporter 1.
CD66: Cluster of differentiation 66.
PDGFRα: Platelet-derived growth factor receptor alpha.
mAb: Monoclonal antibody.
SM: Small molecule.
FAP: Fibroblast activation protein.

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Transformative portfolio expansion across early and late-stage assets

REGENERON[1]
SCIENCE TO MEDICINE®

- Co-development and co-commercialization agreement to develop candidates focused on **alpha therapies**
- **4** initial therapeutic programs, with option for **4 additional programs**
- Up to **$2.1B USD** developmental and commercial milestone payments plus royalties (4 initial programs), with option for 4 additional programs

itm[2]
PASSION FOR PRECISION

- Adds a complementary therapeutic franchise with **multiple pathways for growth**
- **ITM-11 Phase 3 expansion** programs create meaningful commercial opportunities
- Late-stage pipeline supports **label expansion** into G2/G3 GEP-NETs, plus NETs of lung or thymus origin
- Globally scaled commercial-grade supplier - world's largest **supplier of ^{177}Lu**

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1. Telix ASX disclosure April 13, 2026.
2. Telix ASX disclosure September 21, 2026. The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

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Prostate cancer ^{68}Ga PSMA-11 in practice

Dr. Munir Ghesani

Chief Medical Officer United Theranostics



^{68}Ga PSMA-11 has set a high bar in staging and BCR

High-risk, pre-treatment staging[1]
(proPSMA randomized trial, n = 295 with follow up)

Metric	CT + bone scan	^{68}Ga PSMA-11 PET/CT
Accuracy	65% (60–69)	92% (88–95)
Sensitivity	38% (24–52)	85% (74–96)
Specificity	91% (85–97)	98% (95–100)
Management change	15%	28%
Equivocal findings	23%	7%
Radiation exposure	19.2 mSv	8.4 mSv

Biochemical recurrence (Illuccix China study, n = 140)[2]
Patient level PPV 94.8% (95% CI: 85.9%, 98.2%)

Baseline PSA (ng/mL)	PPV (95% CI)
≥ 5.0	100.0% (78.5%, 100.0%)
< 5.0 to 2.0	100.0% (67.6%, 100.0%)
< 2.0 to 1.0	90.9% (62.3%, 98.4%)
< 1.0 to 0.5	90.0% (59.6%, 98.2%)
< 0.5 to 0.2	93.3% (70.2%, 98.8%)

1. Supported by guidelines[3]

2. Same day imaging

3. Reliability and dosing flexibility

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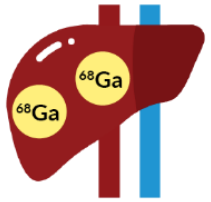
BCR: biochemical recurrence.

1. Hofman, Lancet 2020; Hope, JAMA Oncol 2021; Fendler, JAMA Oncol 2019; Hope, J Nucl Med 2019; Esperto, Cancers 2026.
2. ClinicalTrials.gov ID: NCT05847348. Data on file.
3. NCCN 2025; AUA/ASTRO/SUO 2024; EAU; Telix 2021, 2023 and 2025.

^{68}Ga has a lower propensity for indeterminate bone lesions (IBLs)[1,2]

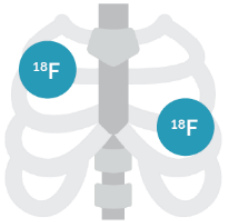
Gallium-68

Free ^{68}Ga is taken up and metabolized through the liver and does not have an affinity to bone.



Fluroine-18

Free ^{18}F has a naturally high affinity to bone.



Free ^{68}Ga, in contrast to ^{18}F, does not have an affinity to bone

With ^{18}F, a number of benign bone lesions accumulate PSMA and result in false positives on PSMA-PET/CT.

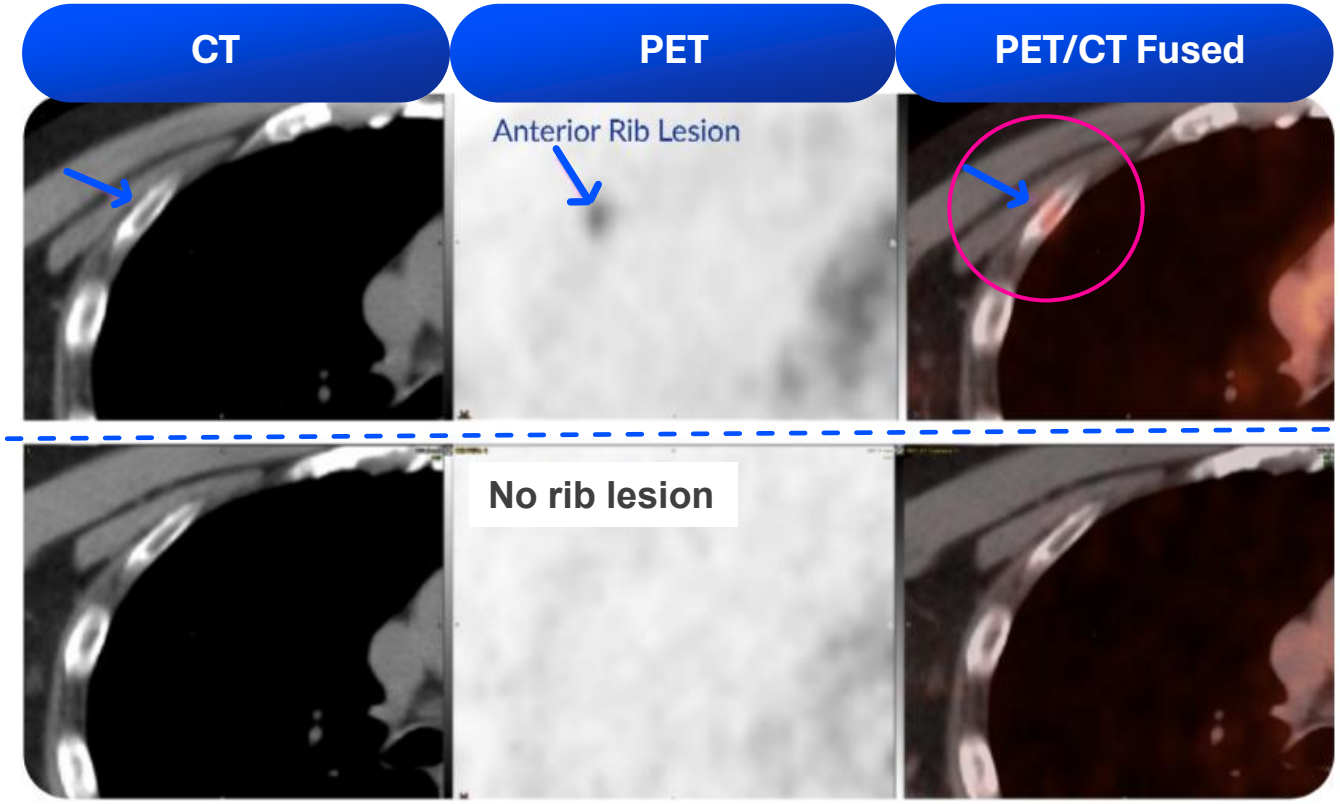
SNMMI Guidelines for Prostate Cancer Imaging

There are numerous advantages of having a more streamlined image pattern that guides you more to where the lesions are and avoids the distractions to where the lesions don't belong. - *Dr. Munir Ghesani*

Telix

1. Kuchar M, et al. *Molecules.* 2015;20(9):16186-16220.
2. Rauscher I, et al. *J Nucl Med.* 2020;61(1):51-57.

Case study: diagnostic accuracy of ^{68}Ga PSMA-11



F-18 PSMA PET Scan

PSA 3.4

- Patient on active surveillance
- No active treatment

IBL detected

^{68}Ga PSMA-11 PET Scan

6 months later

Resolution without interval treatment confirms lesion benignity

Patient representative scans – individual results may vary. Images are non-quantitative.

Interpreting bone lesions with 18F-based PSMA radiotracers can be more challenging compared to 68Ga due to detection of benign bone lesions[1,2] *-SNMMI Guidelines*

Telix

Patient case study from IIT: Intra-Individual Comparison of ^{68}Ga- and ^{18}F-Labeled PSMA PET for Skeletal Lesion Characterization in Prostate Cancer: A Pilot Feasibility, Study Interim Analysis led by Dr Ghesani.

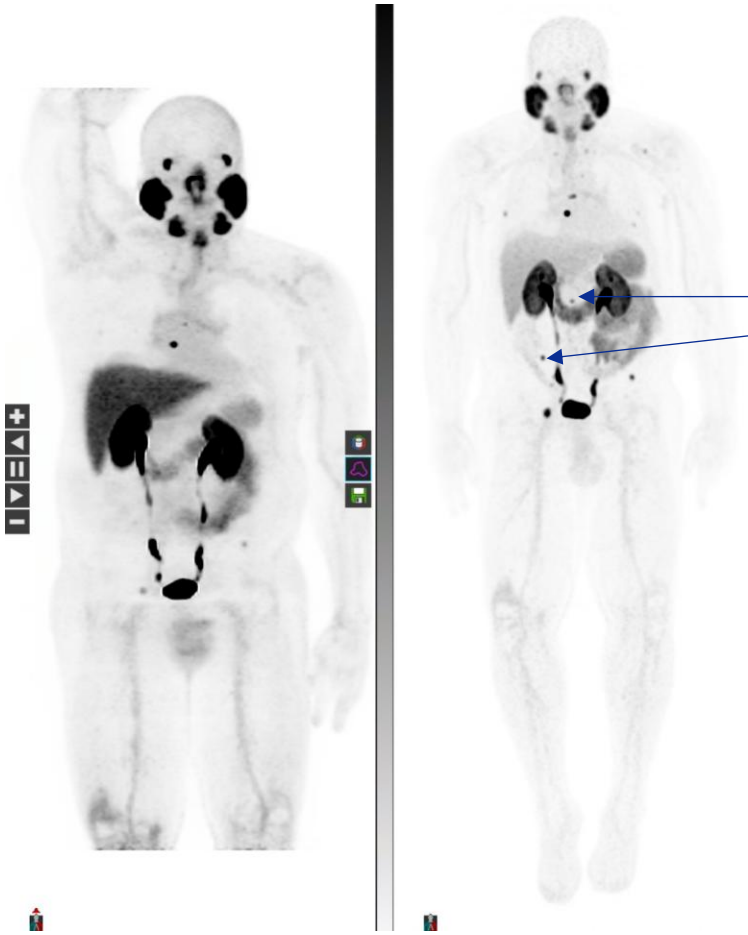
1. Fendler WP, et al. PSMA PET/CT: joint EANM procedure guideline/SNMMI procedure standard for prostate cancer imaging 2.0. Eur J Nucl Med Mol Imaging, 2023.
2. Lowrance W, et al. Updates to advanced prostate cancer.

Case Study

68-year-old male; Gleason 9 (4+5) prostate cancer; PSA is 112; Referred for 177Lu-PSMA Therapy (Pluvicto)

^{18}F-PSMA PET Scan

^{68}Ga PSMA-11 PET Scan



Multiple lesions accurately identified on ^{68}Ga PSMA-11 PET Scan, but not on ^{18}F-PSMA PET Scan

MIP[1] Images

Patient representative case study for educational purposes only. Individual responses may differ. Does not constitute medical advice or solicitation. Consult product labelling.

1. Maximum Intensity Projection.

Beyond standard imaging, enhancing lesion detection through delayed ^{68}Ga PSMA-11 PET imaging

50–100 mins

Labelled acquisition window

U.S. prescribing information for gallium ^{68}Ga PSMA-11.[1]

68 mins

Physical half-life of ^{68}Ga

Approximately one quarter of administered activity remains at 150 min; decay is continuous, not a cut-off.[1]

>120 mins

Permitted for indeterminate findings

Joint EANM/SNMMI PSMA PET/CT guideline 2.0, including sites adjacent to the urinary tract.[2]

Telix

1. Gozellix Prescribing Information April 2025.
2. Fendler et al., Eur J Nucl Med Mol Imaging 2023.

Study design evaluating delayed acquisition with ^{68}Ga PSMA-11

EARLY scan

~60 mins

standard acquisition

DELAYED scan

150 mins

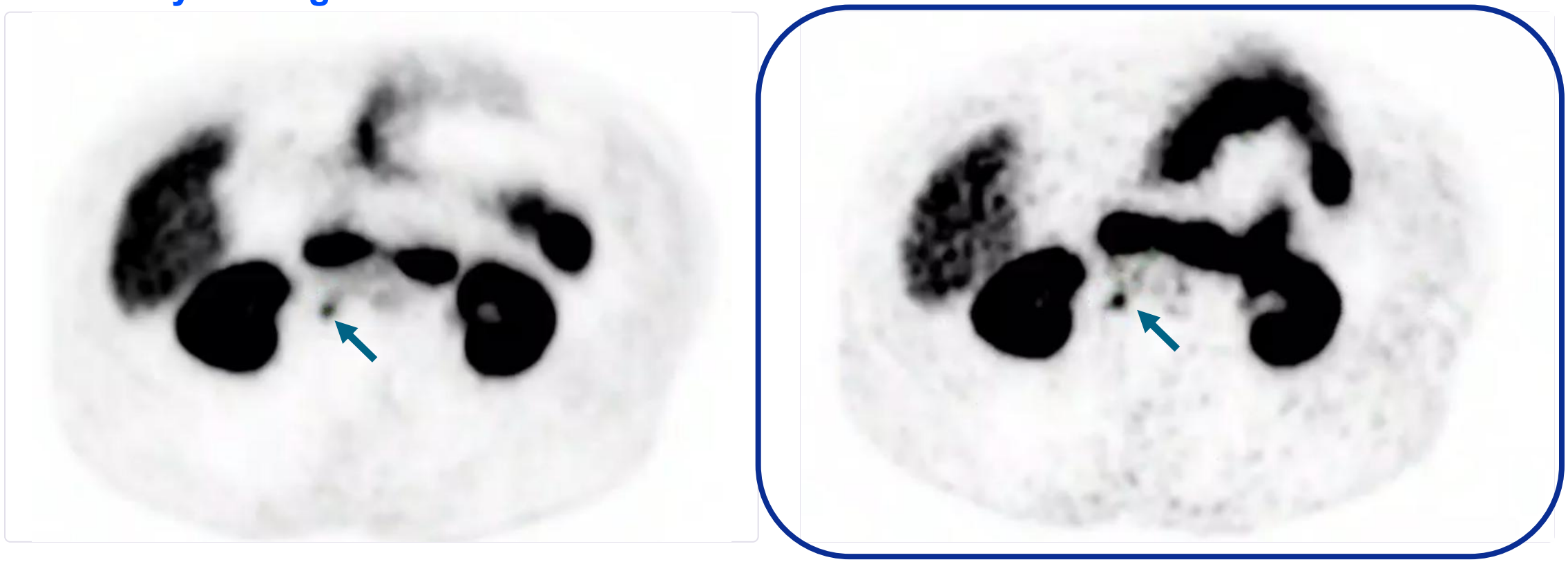
extended list-mode, fractionally reconstructed

Design	Prospective pilot
Enrolled	3 patients, prostate cancer
Liver analysis	3 cases, fractional reconstructions
Lesion analysis	13 paired lesions, 3 cases

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Higher lesion-to-background contrast observed with delayed imaging

Case study 1 using ^{68}Ga PSMA-11



Early · 60 mins

Delayed · 150 mins

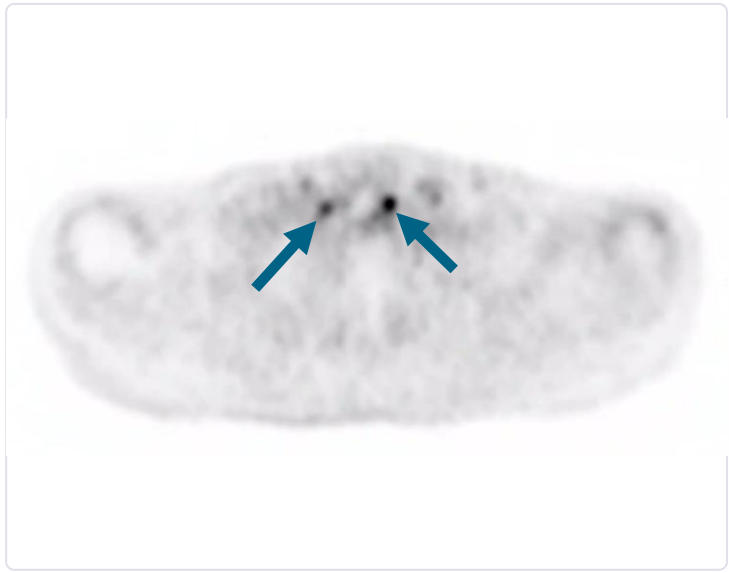
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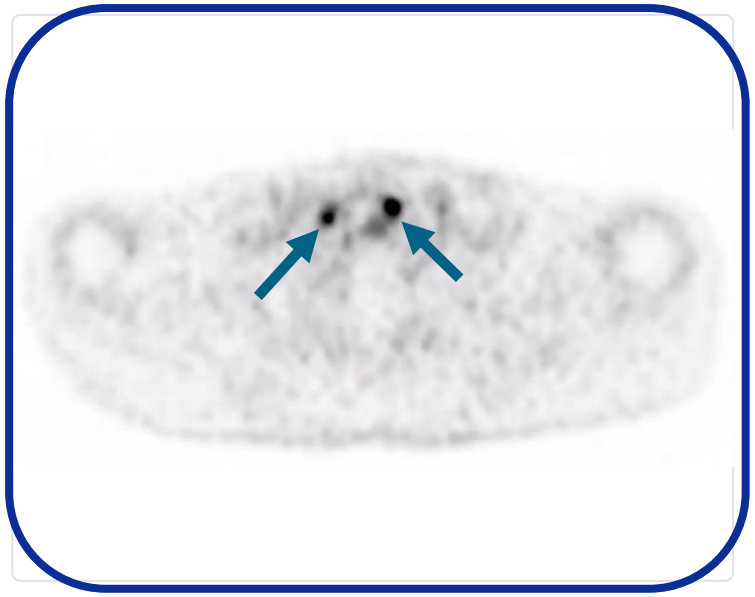
Higher lesion-to-background contrast observed with delayed imaging

Case 2 using ^{68}Ga PSMA-11

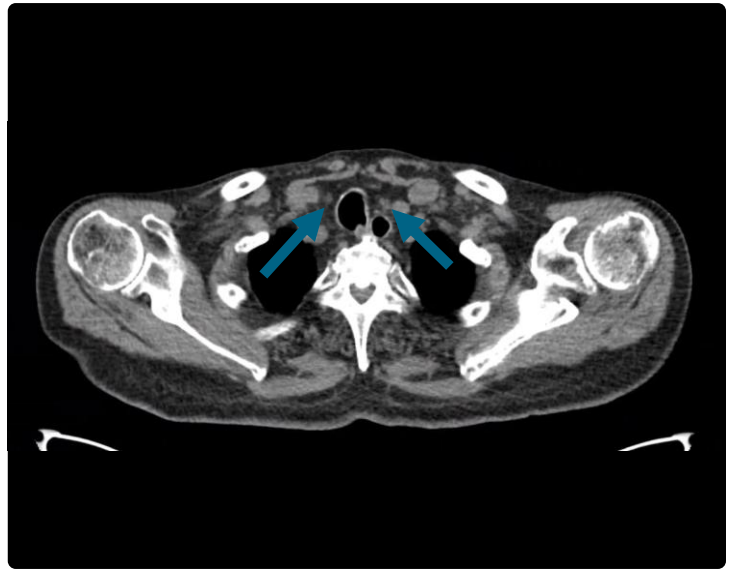
Paratracheal lymph nodes



Early · 60 mins



Delayed · 150 mins



CT correlate · bilateral paratracheal nodes

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Delayed imaging with ^{68}Ga PSMA-11 preserves lesion uptake, with a modest increase in SUV peak

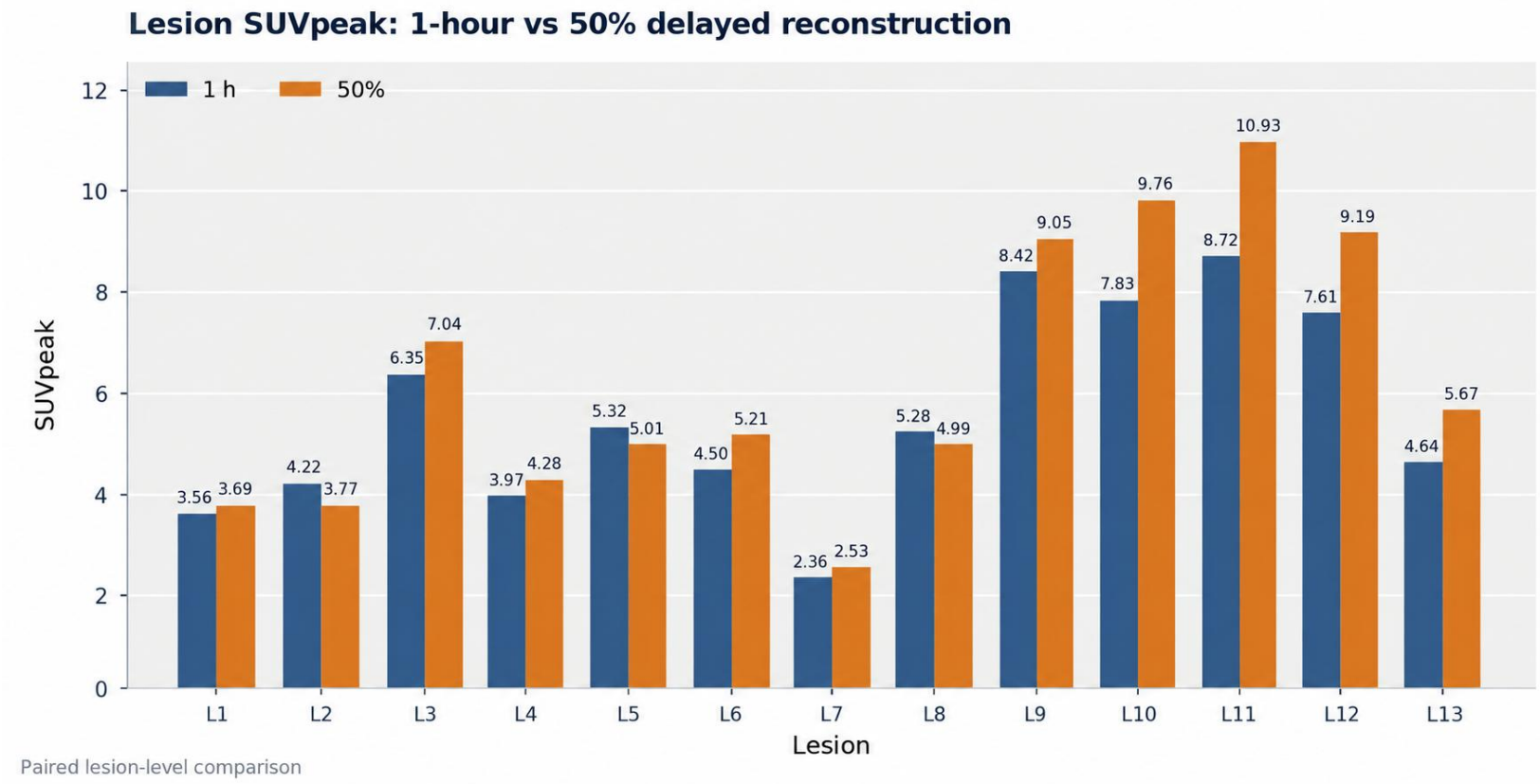
10/ 13

lesions with higher delayed SUVpeak

+8%

median paired change · range −10.7% to +25.3%

1 h vs 50% delayed reconstruction
· mean SUVpeak 5.60 vs 6.24



Source: Study results provided by Dr. Munir Ghesani.

Can delayed imaging with 64-Cu-DOTATATE improve lesion clarity adjacent to physiological uptake?

PREVAILING ASSUMPTION

“Delayed imaging is clearer because background tracer washes out.”

PRIMARY HYPOTHESIS

Early imaging yields superior overall lesion clarity and a more uniform hepatic background, because count density, not clearance, dominates perceived quality.

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Note: Study protocol developed and conducted by Dr. Ghesani.

Study design evaluating delayed acquisition with 64-Cu-dotatate

A paired, within-patient design with blinded two-alternative forced choice

Design	Retrospective, paired
Cohort	20 patients, SSTR-positive NET
Readers	3 board-certified NM physicians
Display	Matched anatomy, window, liver-normalized

EARLY

~1 h

post-injection

DELAYED

~24 h

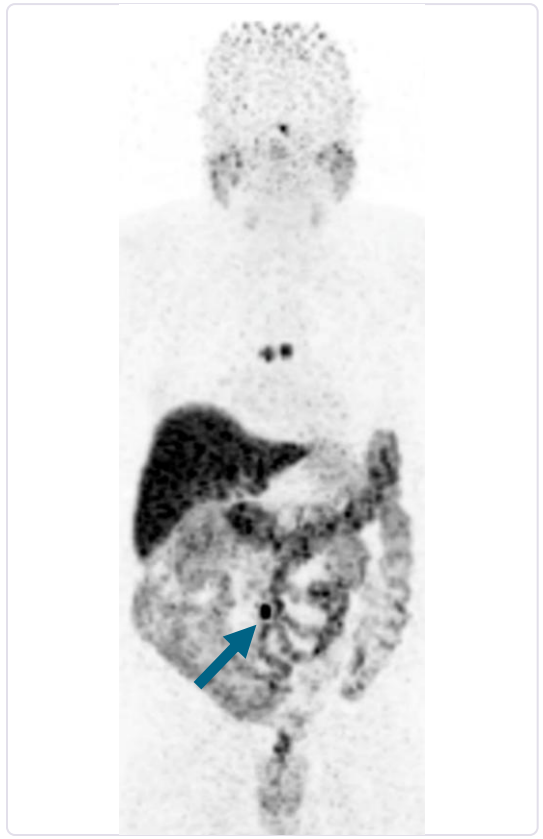
post-injection

Telix

Note: Study protocol developed and conducted by Dr. Ghesani.

24-hour delayed imaging shows reduced image uniformity

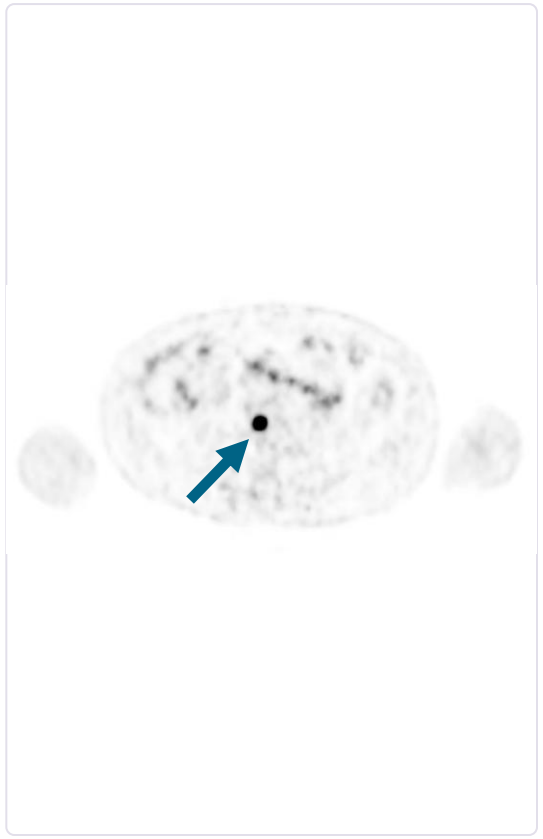
Case 1 using 64-Cu-dotatate



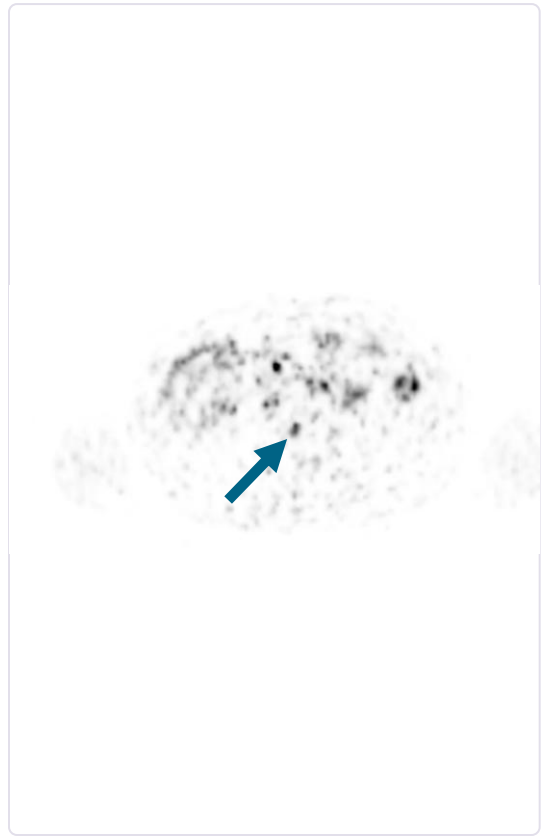
MIP · 1 h



MIP · 24 h



Axial · 1 h



Axial · 24 h

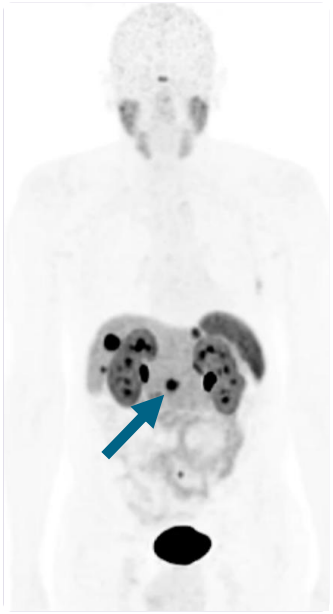
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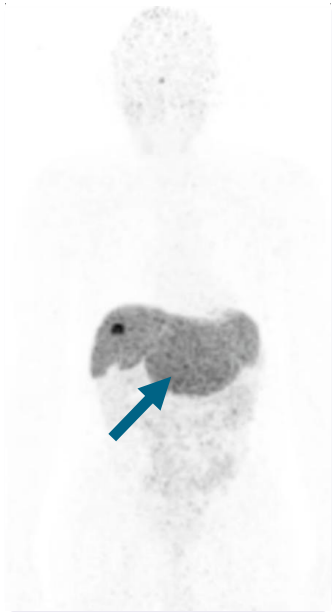
Note: Study protocol developed and conducted by Dr. Ghesani.

A hepatic lesion conspicuous at 1h was not visible at 24h

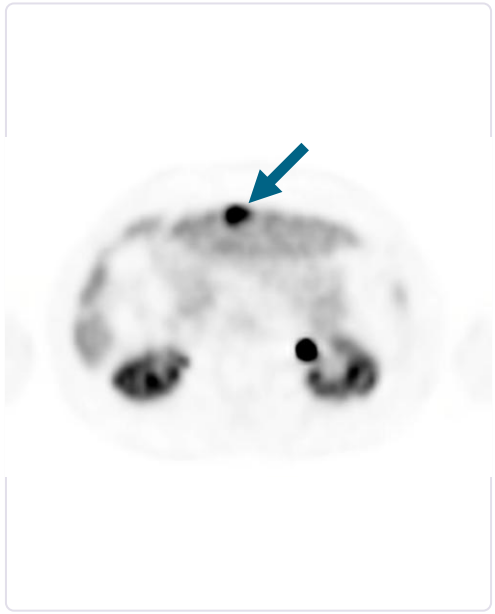
Case 2 using 64-Cu-dotatate



MIP · 1 h



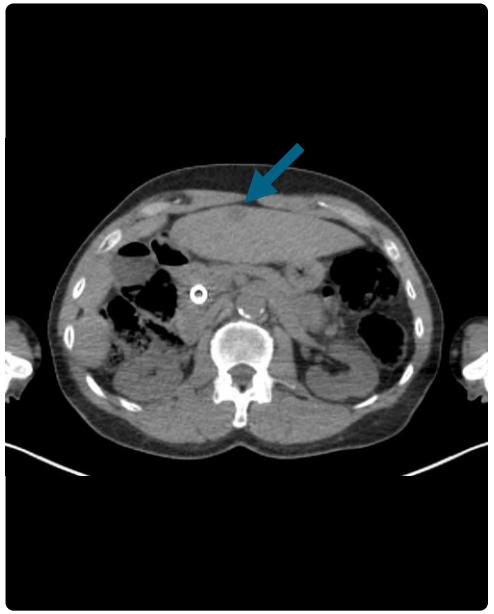
MIP · 24 h



Axial PET · 1 h



Axial PET · 24 h



CT correlate

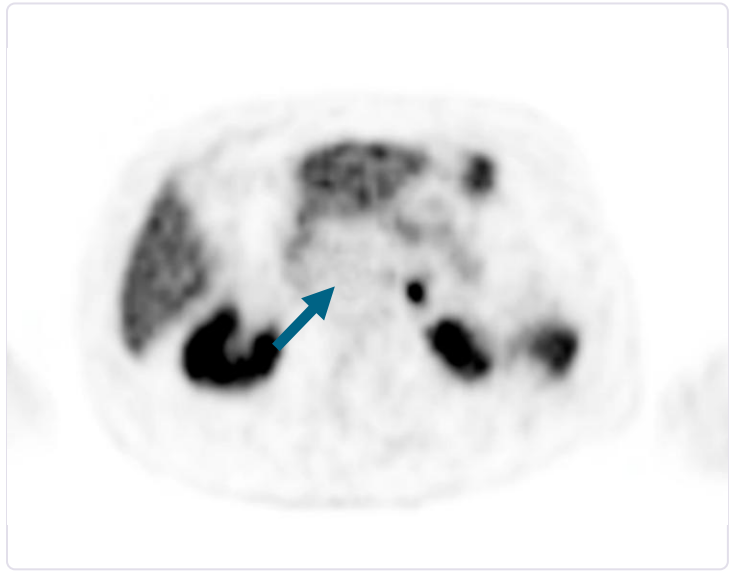
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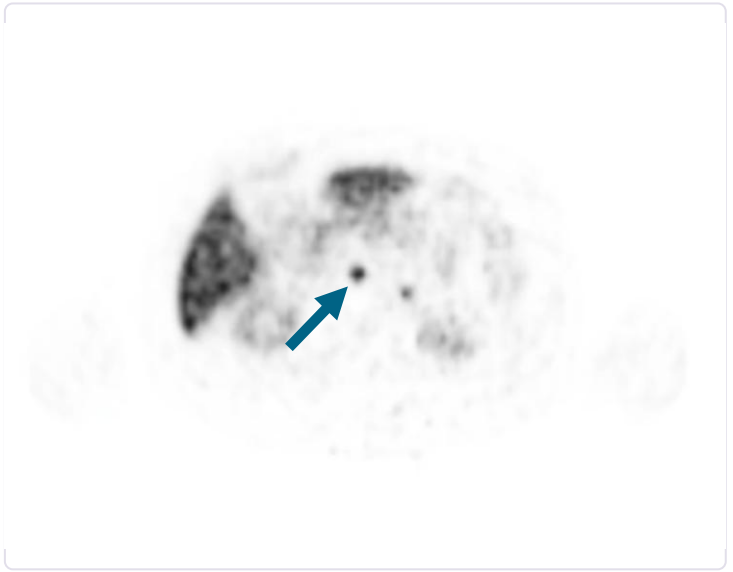
Note: Study protocol developed and conducted by Dr. Ghesani.

A retroperitoneal lymph node absent at 1 hour became conspicuous at 24 hours

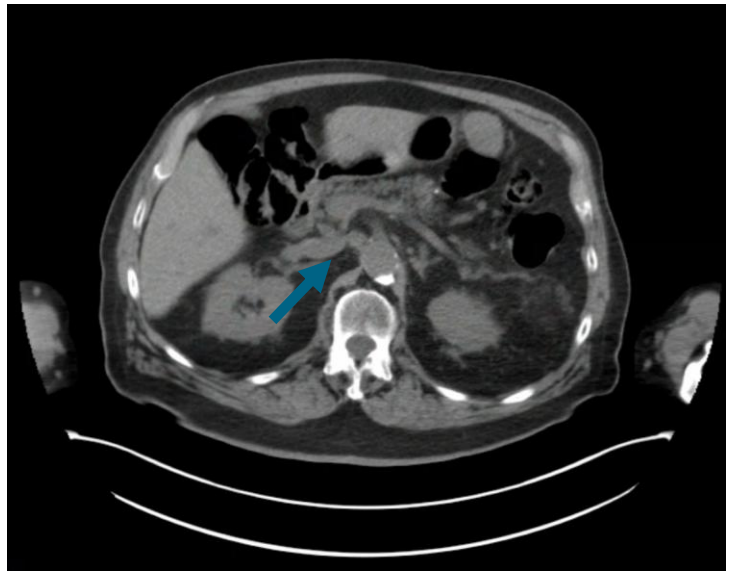
Case 3 using 64-Cu-dotatate



Axial PET · 1 h · no focal retroperitoneal uptake



Axial PET · 24 h · left para-aortic focus



CT correlate · retroperitoneal node, distinct from ureter

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Note: Study protocol developed and conducted by Dr. Ghesani.

^{64}Cu-dotatate results

Variable lesion detection and heterogeneity between 1h and 24h with Cu imaging

EARLY ALONE

104

lesions

DELAYED ALONE

82

lesions

COMBINED REVIEW

115

lesions · +11 over early alone

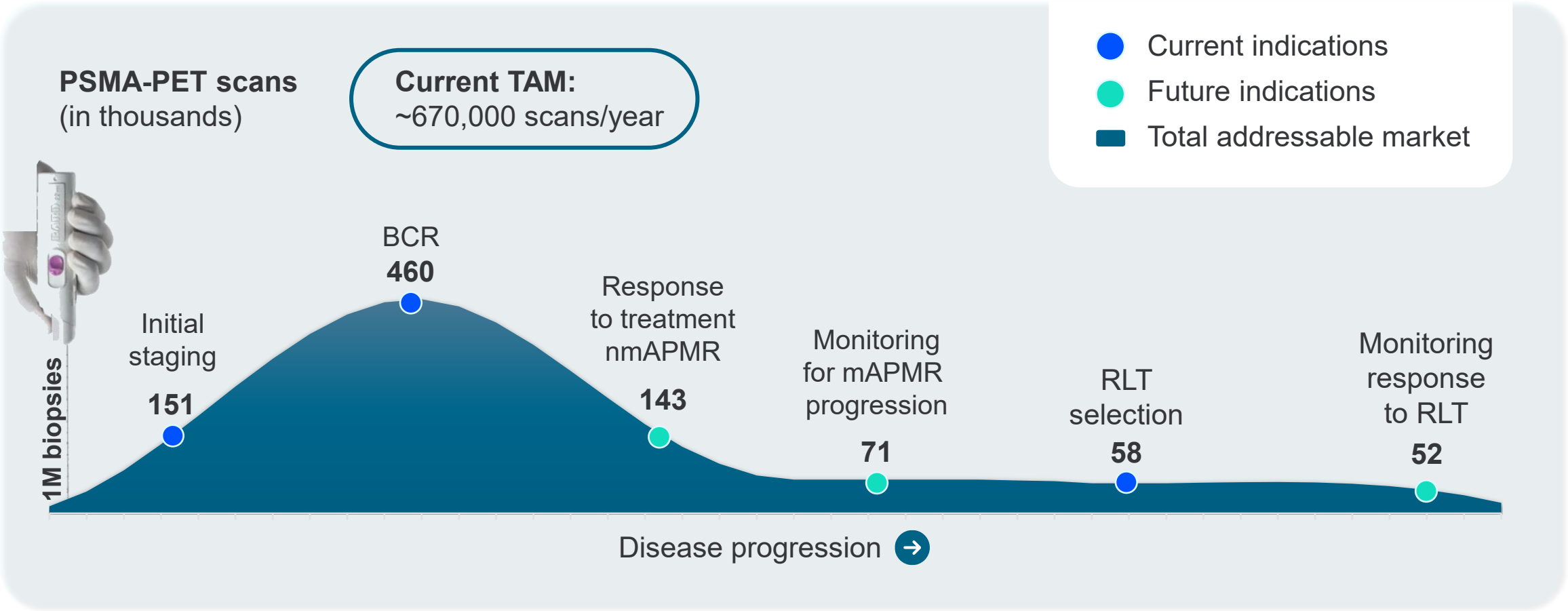
Some lesions seen at 1 hour were no longer appreciable at 24 hours; some became apparent only after clearance of adjacent physiological activity.

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Note: Study protocol developed and conducted by Dr. Ghesani.

Current state: PSMA-PET transformed staging and BCR detection

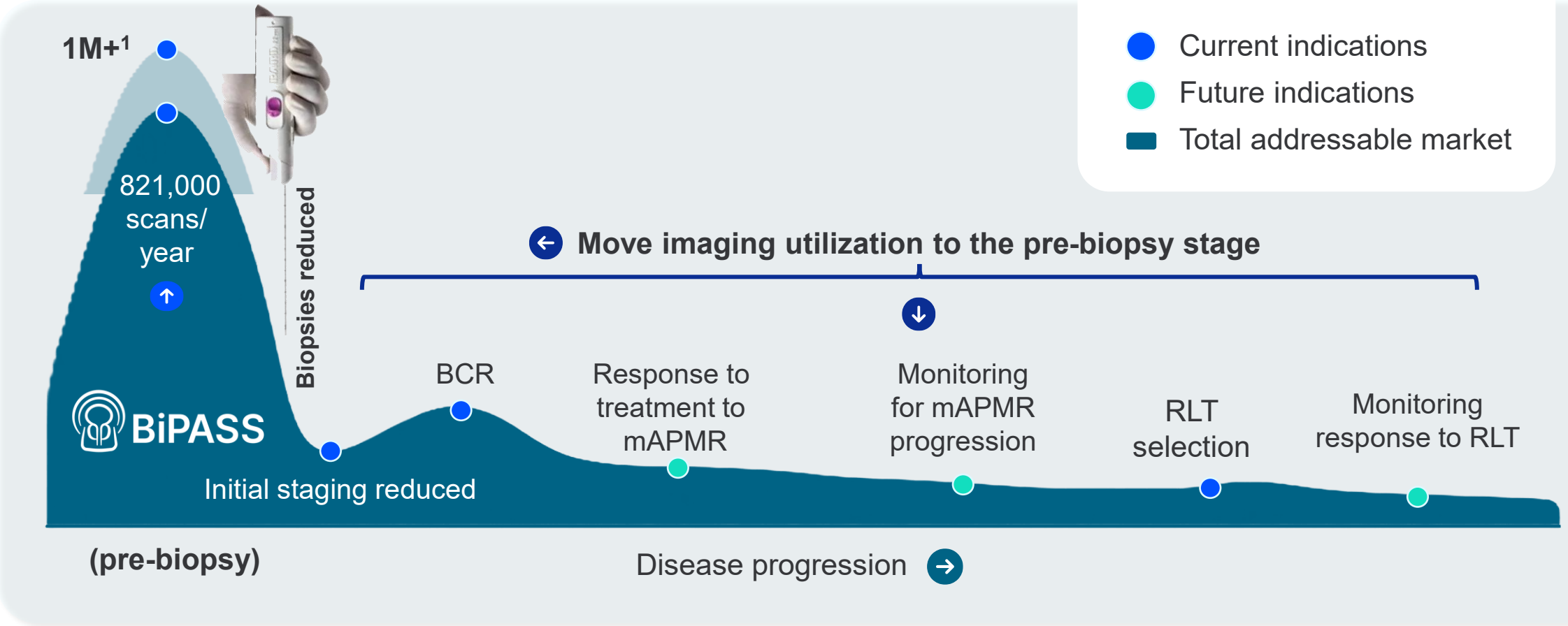
Initial biopsy protocol has remained unchanged since the addition of MRI



TAM = Total addressable market, BCR = Biochemical recurrence, nmAPMR = non-metastatic androgen pathway modulation resistant, RPT = Radiopharmaceutical therapies.
ClinicalTrials.gov: NCT07052214. Annual PSMA-PET scan volume in the U.S. based on internal estimates.

Future state: BiPASS revolutionizes biopsy decision-making

Potential to double the size of the existing PSMA market



BiPASS = Biopsy of the Prostate Avoidance Stratification Study, TAM = Total addressable market, RPT = Radiopharmaceutical therapies, Annual PSMA-PET scan volume in the U.S. based on internal estimates.

1. Estimate one million biopsies performed in the U.S. each year. Source: Schmeusser et al. Therapeutic Advances in Urology, 2022.
2. ClinicalTrials.gov: NCT07052214.

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Prostate cancer diagnosis

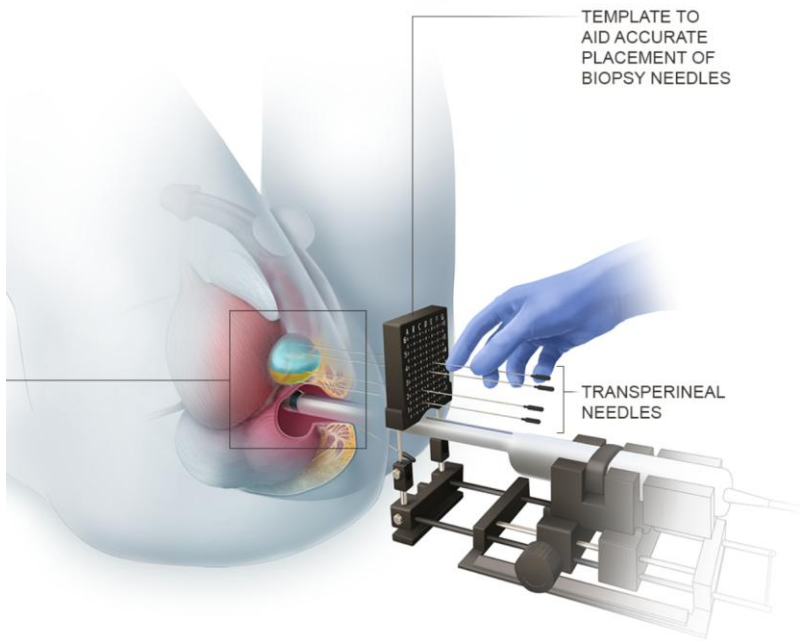
Dr. Philip Dundee

Urological surgeon



Current diagnostic pathway for prostate cancer relies on invasive biopsies

Template biopsy



- Template biopsies require 15-20 samples obtained through an invasive procedure under anesthesia[1]
- Sampling limitations may miss disease or fail to characterize tumor burden. Biopsies are blind to the tumor location[2]
- Risks of infection, bleeding, urinary retention, post-procedural complications[3]
- Recovery times may vary from days to weeks[4]
- Multiple biopsies are often required to diagnose, monitor progression or confirm treatment response[2]

1. Prostate Cancer Diagnosis | Johns Hopkins Medicine
2. Schmeusser B, Levin B, Lama D, Sidana A. Hundred years of transperineal prostate biopsy. *Ther Adv Urol*. 2022;14:17562872221100590. Published 2022 May 21. doi:10.1177/17562872221100590.https://www.researchgate.net/figure/Complications-of-transrectal-ultrasound-guided-prostate-biopsy_tbl1_10978264
3. Transperineal Biopsy Preparation | University Urology

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A significant unmet need remains in the diagnostic pathway

Men with elevated PSA values will often be recommended for MRI[1], followed by biopsy

- MRI is not specific and often inconclusive, leading to biopsy

Biopsies carry real risks[4]

- Hematuria, rectal bleeding, hematospermia
- Inconsistent practice around anticoagulants adds complexity

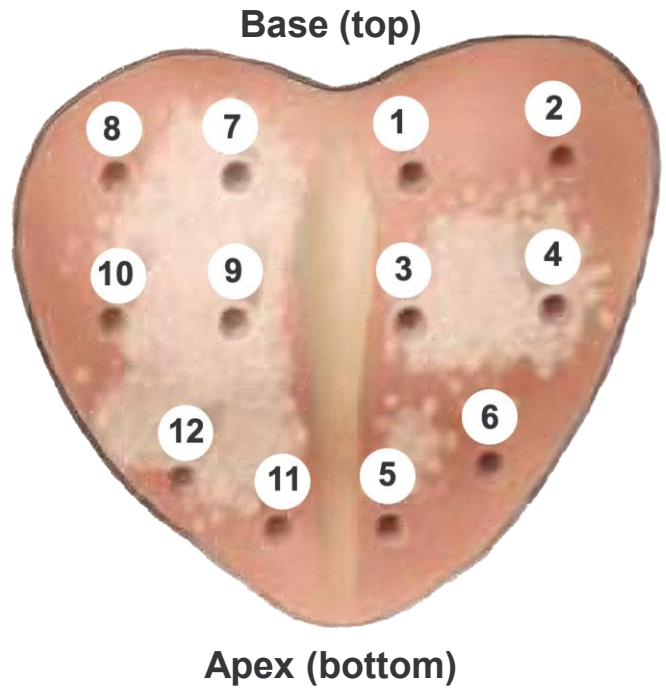
800,000 biopsies performed in the U.S. each year, up to 75% are negative[2]

- Biopsy is blind to the location of cancer in the prostate
- Only ~half of the needles provide useful samples (false negatives)[3]

Up to 25% of patients refuse a recommended biopsy[5]

- Reasons for refusal include fear or pain of complications
- Skepticism about the necessity of the procedure

Areas of biopsy[6]



Biopsy false-negative rates can be as high as 50%[7]

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1. Magnetic resonance imaging. 2. Vickers et al. *J Clin Oncol.* 2010. 3. Ahmed et al. *Lancet. 2017*. 4. https://www.researchgate.net/figure/Complications-of-transrectal-ultrasound-guided-prostate-biopsy_tbl1_10978264 5. Filho et al., 2025. 6. Picture credit: Georgia Radiation Therapy. 7. Schmeusser B, Levin B, Lama D, Sidana A. Hundred years of transperineal prostate biopsy. *Ther Adv Urol.* 2022;14:17562872221100590. Published 2022 May 21. doi:10.1177/17562872221100590.

Key insights from PRIMARY and PRIMARY2 Investigator Initiated Studies (IITs)

PRIMARY (n = 291)[1]	Ga-PSMA-PET +mpMRI	mpMRI
Sensitivity	97%	83%
Specificity	40%	53%
Negative predictive value	91%	72%
PRIMARY SCORE[2] (analysis)		
Sensitivity	94%	89%
Specificity	68%	74%
P-Score[3] (analysis)		
Sensitivity	94%	89%
Specificity	66%	74%

PRIMARY2[4] (n = 660)	Ga-PSMA-PET +mpMRI
Biopsy reduction	49%
csProstate cancer detected	12% vs 16%

PRIMARY study established proof of concept that Ga-PSMA-11 PET + mpMRI improves the detection of prostate cancer.

PRIMARY2 study demonstrated that Ga-PSMA-11 PET + mpMRI can safely reduce biopsies while maintaining a clinically significant detection of prostate cancer.

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1. Emmett L, Buteau J, Papa N, et al. *Eur Urol*. 2021.
2. Emmett L, Papa N, Buteau J, et al. *J Nucl Med*. 2022.
3. Emmett L, Papa N, Hope TA, et al. *J. Urol*. 2024.
4. Buteau JP, Moon D, Fahey MT, et al. *Lancet Oncol*. 2026.

BiPASS® Phase 3 study for detection of prostate cancer

Biopsy of the Prostate Avoidance Stratification Study (BiPASS)

Registrational study

^{68}Ga-PSMA-11 + mpMRI PI-RADS 1-4 → **Template biopsy (targeted biopsy)** → 6- month follow-up (confirm negative findings)

n = 350

Primary Objective:
Detection of clinically significant prostate cancer using mpMRI + ^{68}Ga-PSMA-11 PET[1]

Co-primary endpoints:
Sensitivity and specificity

Global, multi center, open label, single arm study



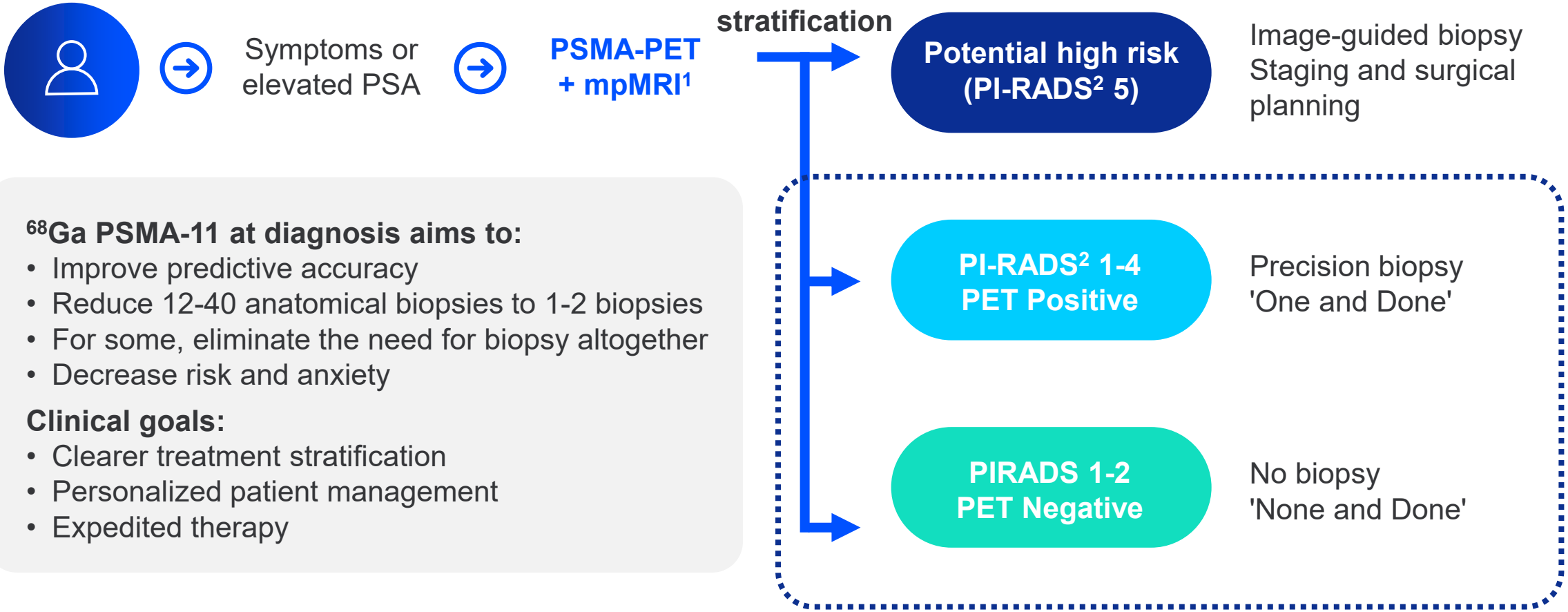
Eligibility: Clinical suspicion of prostate cancer and indicated for template biopsy
Status: Completed patient enrollment

Clinicaltrials.gov: NCT07052214

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mpMRI = multiparametric Magnetic Resonance Imaging.
1. Histopathological confirmation will be used to detect prostate cancer.

A more precise diagnostic pathway with ^{68}Ga PSMA-11, enabling targeted use of biopsy



^{68}Ga PSMA-11 at diagnosis aims to:

- Improve predictive accuracy
- Reduce 12-40 anatomical biopsies to 1-2 biopsies
- For some, eliminate the need for biopsy altogether
- Decrease risk and anxiety

Clinical goals:

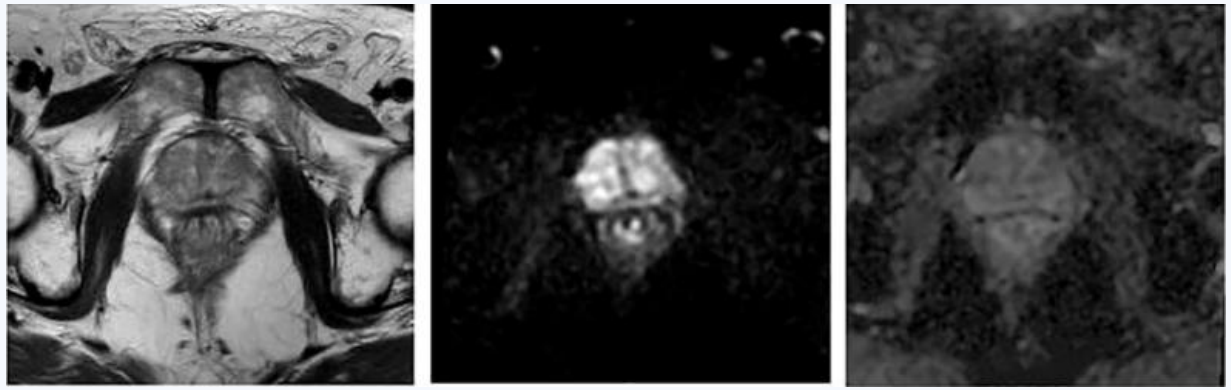
- Clearer treatment stratification
- Personalized patient management
- Expedited therapy

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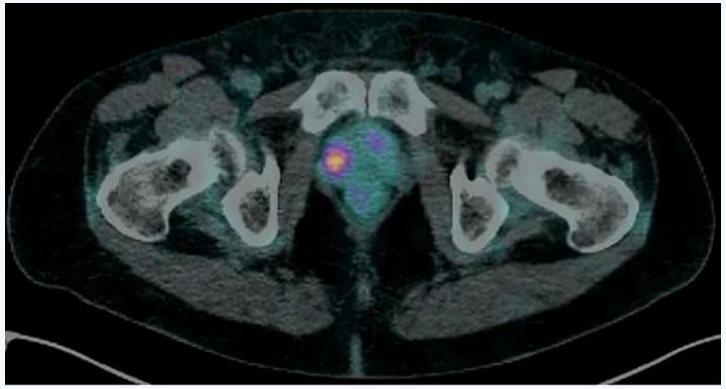
1. Multiparametric Magnetic Resonance Imaging.
2. Prostate Imaging Reporting and Data System, a scoring system used by radiologists to assess the likelihood of prostate cancer based on multiparametric mpMRI findings.

The future of prostate cancer detection

Current state
3 MRI acquisitions



Future state
1 PSMA PET scan



- 72 year old male was negative for suspicious findings (PI-RADS <3)
- PSMA PET detected a focal uptake in the right anterior apex of the prostate[1]

Patient representative scans – individual results may vary. Images are non-quantitative.

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1. Celli M, Gunelli R, Ferroni F, Costantini M, Barone D, Fantini L, Fragalà E, Marini I, Di orio V, Foca F, Monti M, Matteucci F and Caroli P (2026) Toward a PSMA PET–mpMRI pathway for biopsy decision-making in men with suspected prostate cancer: interim results from the prospective BIOPSTAGE trial. Front. Oncol. 15:1720861. doi: 10.3389/fonc.2025.1720861.

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Brain cancer overview (select programs)



Prof. Andrew Scott

Head of Tumour Targeting Laboratory Olivia Newton-John Cancer Research Institute

First FDA approved imaging agent for gliomas (U.S.)

Pixclara®
(floretyrosine F 18)

- Pixlumi®[1] **MAA accepted** in Europe
- Included in National Comprehensive Cancer Network **(NCCN®) guidelines**
- Inclusion in **International guidelines:** EANM/EANO/RANO/SNMMI
- Expanding into new indication: **brain metastases**[2]
- Addresses high unmet need – helps to differentiate tumor progression vs. treatment effects[3]
- Granted orphan drug designation[4]

First-in-class imaging agent approved for glioma[1]

Telix

MAA = Marketing authorization application. EANM = European Association of Nuclear Medicine. EANO = European Association of Neuro-Oncology. RANO = Response Assessment in Neuro-Oncology. SNMMI = Society of Nuclear Medicine and Molecular Imaging.
1. Launch and brand names subject to final regulatory approval. 2. ASX release July 20, 2026. 3. Telix ASX disclosure September 14, 2026. 4. Telix ASX disclosure October 6, 2020.

Clinician impact

~70%

of physicians surveyed indicated they are ready to prescribe Pixclara upon FDA approval

~80%

of referrers rely on NCCN guidelines when ordering imaging for glioma



Key insights

>90%

availability of PET scanners in-house

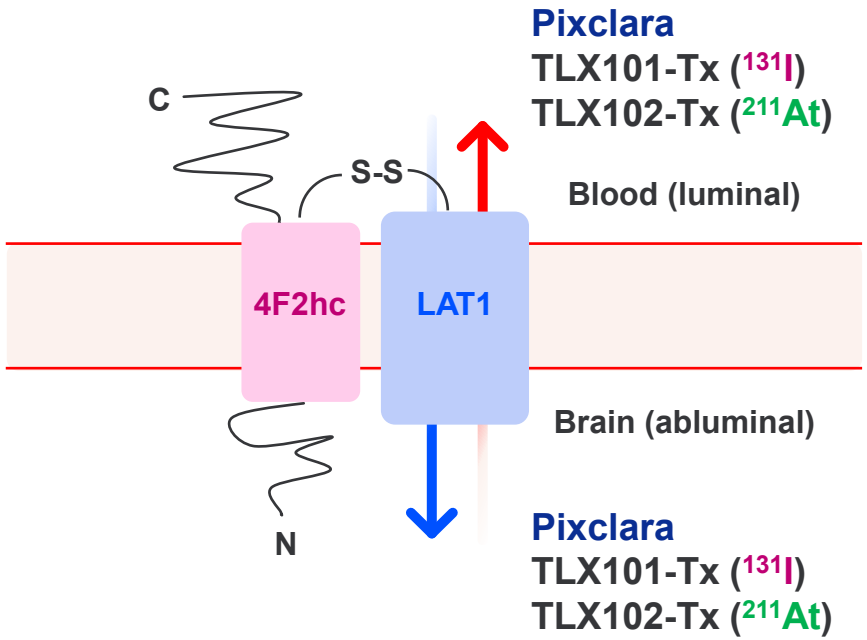
Majority of referrers rank high differential uptake in glioma and high image quality
as the most important features of a PET radio tracer

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Insights based Shoreline Research, Awareness trial and utilization report, January 2026.

A novel mechanism of action overcoming the blood brain barrier

Targeted radiation that provides imaging and therapeutic potential



- Large amino acid transporters, LAT1 and LAT2 are highly expressed in gliomas[1,2] compared to normal tissue
- LAT1 is expressed on both luminal and abluminal membranes, playing a key role in BBB permeation[2,3]
- Pixclara targets LAT1 and LAT2 while TLX101-Tx and TLX102-Tx therapeutic candidates target LAT1

A potential first-in-class theranostic pairing in neuro-oncology

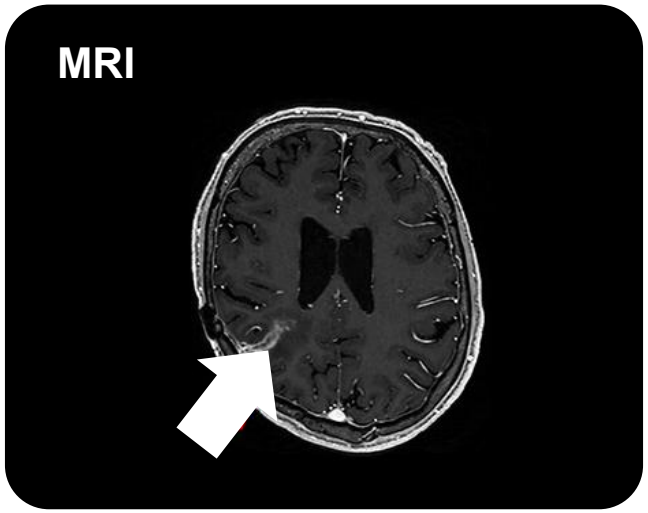
Telix

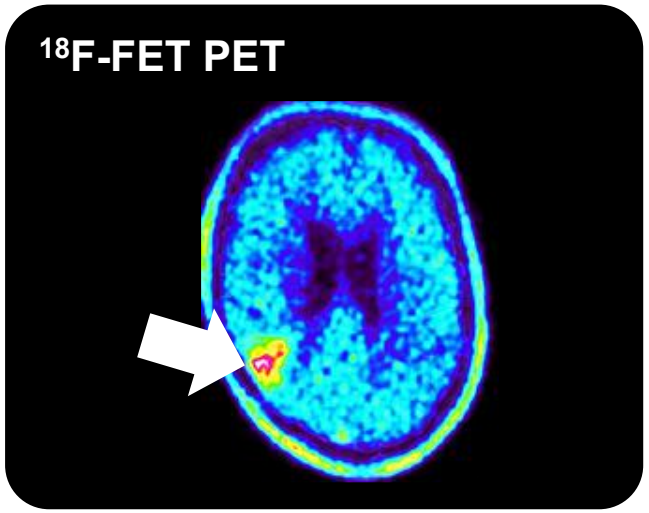
1. Singh N and Ecker GF. *Int J Mol Sci.* 2018;19(5):1278.
2. Haining Z, et al. *BMC Clin Pathol.* 2012;12:4.
3. Ahmed HS. *Mol Neurobiol.* 2025;62(3):3813-3832.

Existing imaging modalities have meaningful limitations

Our amino acid PET tracer, TLX101-Px represents an innovative advancement in imaging

A side-by-side comparison of sequential T1-weighted post contrast MRI and ^{18}F-FET of the same patient





Patient representative scans – individual results may vary.

Post-contrast MRI scan showing an enhancing region that was inconclusive

^{18}F-FET demonstrated focal uptake laterally near the margins of the resection cavity with a TBRmax of 3.2, meeting the threshold for recurrent disease

Limitations of CE MRI

MRI, the current SoC for imaging of gliomas, yields inconclusive results[1,2]

- Fails to reflect the entire extent of glioma, leading to undertreatment
- Mistake treatment related changes as tumor recurrence, leading to over treatment

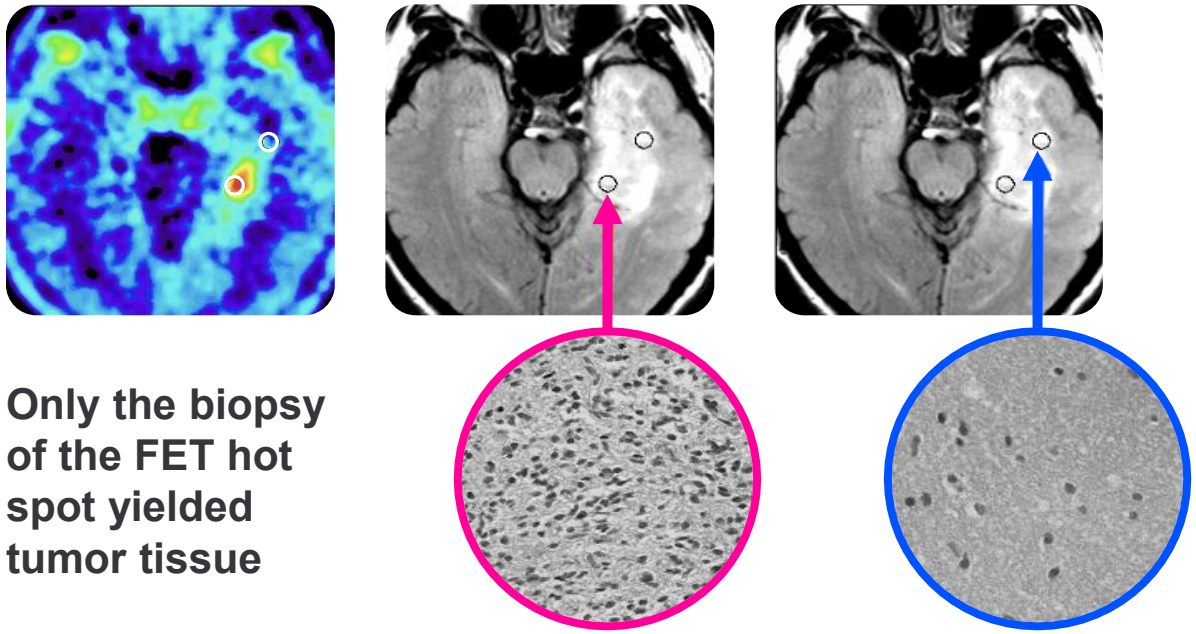
Combining amino acid PET tracers with anatomical MRI improves diagnostic accuracy in primary and secondary brain tumors[3] and supports clinical decision making

Note: CE-MRI = contrast enhanced MRI, TBR = Tumor to background ratio

1. Law I, Albert NL, Arbizu J, et al. Joint EANM/EANO/RANO practice guidelines/SNMMI procedure standards for imaging of gliomas using PET with radiolabelled amino acids and [18F]FDG: version 1.0. *Eur J Nucl Med Mol Imaging.* 2019;46(3):540-557. 2. Rosen J, Ceccon G, Bauer EK, et al. Cost effectiveness of 18F-FET PET for early treatment response assessment in glioma patients after adjuvant temozolomide chemotherapy. *J Nucl Med.* 2022;63(11):1677-1682. 3. NCCN Guidelines: https://www.nccn.org/guidelines/guidelines-detail?category=1&id=1425.

Pixclara brand name is subject to final regulatory approval.

Combining TLX101-Px with MRI has demonstrated sensitivity of 93% and specificity of 94% for detection of gliomas



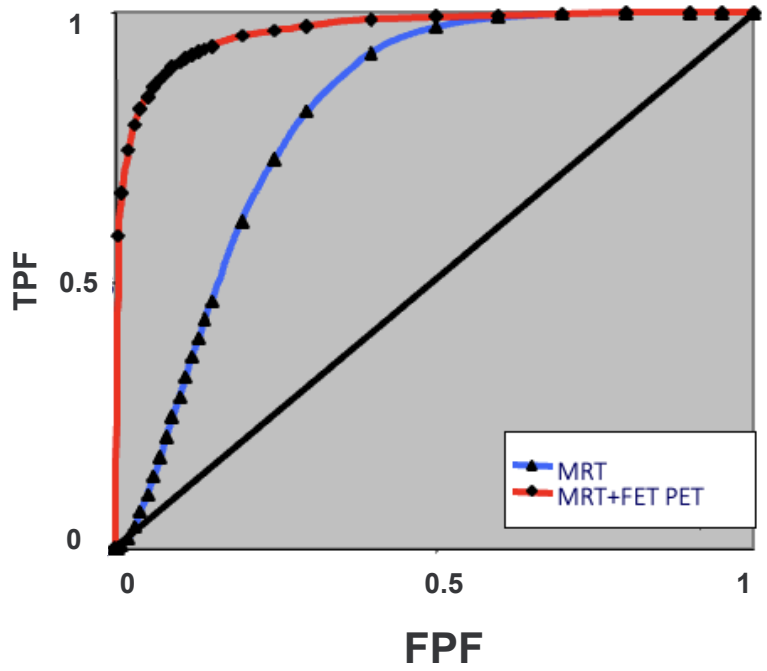
Only the biopsy of the FET hot spot yielded tumor tissue

CNS WHO grade 3 astrocytoma

Reactive astrogliosis

MRI alone → **Sens, 96%; Spec., 53%**
MRI & FET PET → **Sens, 93%; Spec., 94%**

Comparison of FET PET with standard MRI for the detection of tumor tissue
Imaging findings were evaluated histologically

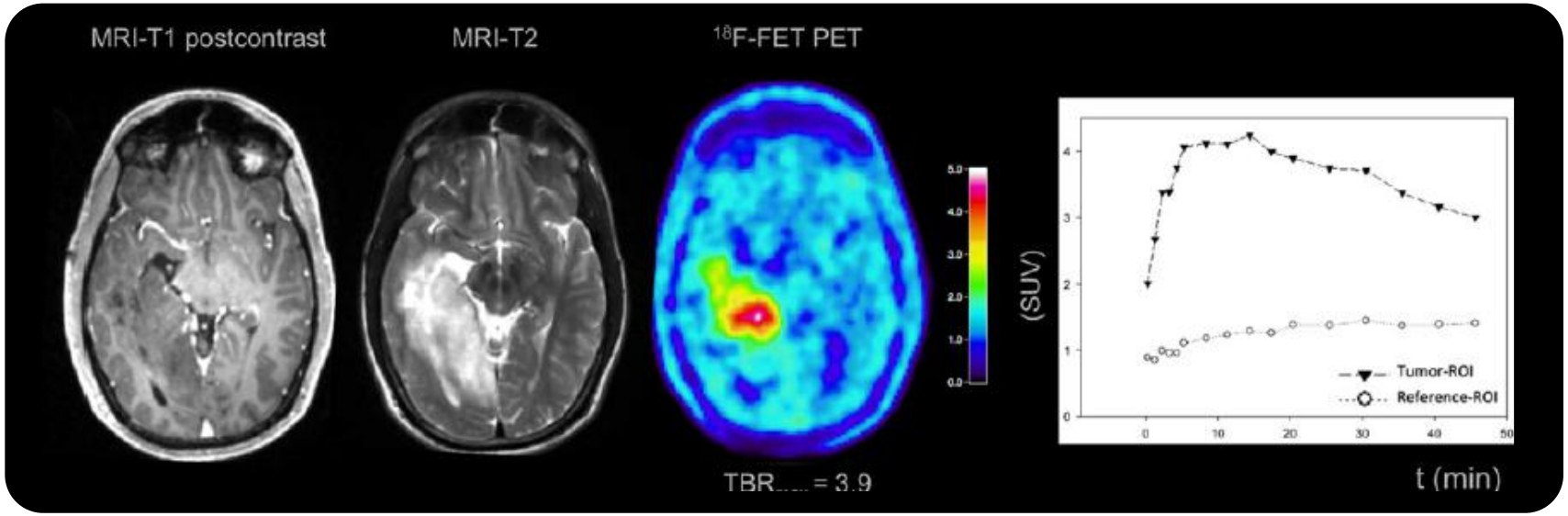


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Pauleit et al. *Brain.* 2005.
Patient representative scans – individual results may vary.

TLX101-Px in combination with MRI differentiates between treatment related changes and disease progression

Patient representative scans – individual results may vary.



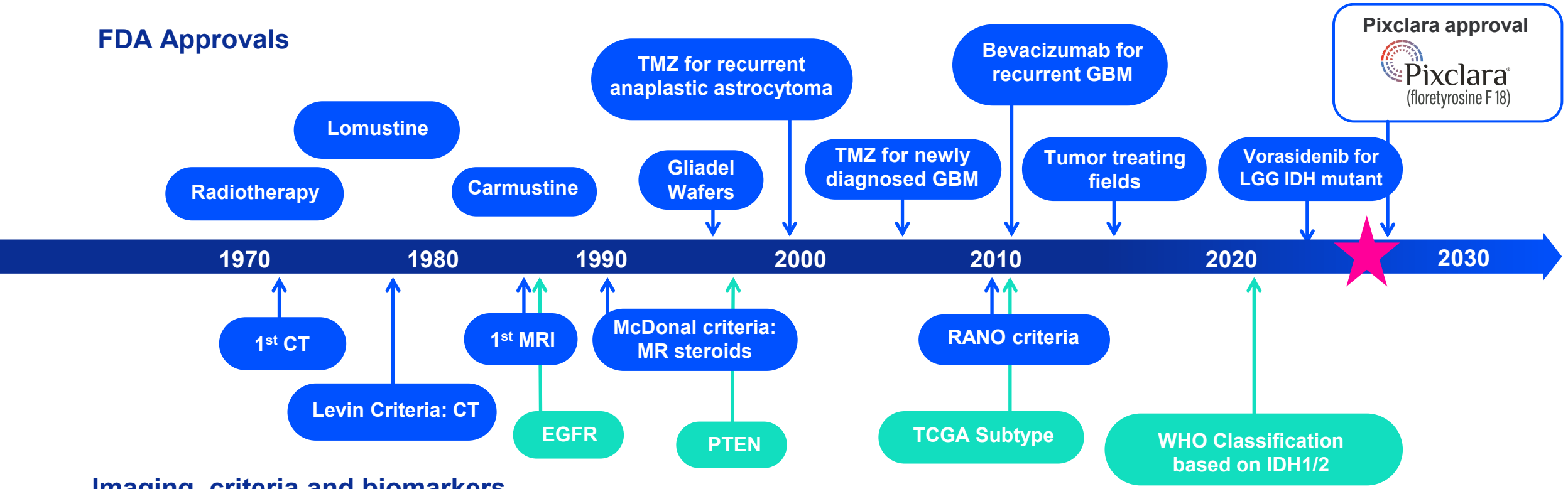
A 35-year-old patient with initial diagnosis of a diffuse astrocytoma (WHO grade II). Follow-up MRI 86 months after initial diagnosis showed a slight progression of the hyperintensity in the T2-weighted MRI, but no clear contrast enhancement in the right temporal. In contrast, ^{18}F-FET shows highly increased metabolic activity (TBRmax, 3.9) in the right temporal, and the time–activity curve shows an early ^{18}F-FETuptake (20 min) followed.

After a stereotactic-guided biopsy of the metabolically active tumor, histological examination was consistent with a malignant progression to an anaplastic oligoastrocytoma (WHO grade III).

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Galldiks, et al. The use of dynamic O-(2-18F-fluoroethyl)-L-tyrosine PET in the diagnosis of patients with progressive and recurrent glioma. Neuro-oncology vol. 2015.

Standard of care has remained unchanged for the past two decades despite rapid innovation in oncology



GBM presents a significant and persistent unmet need for patients

Telix

Note: TMZ = temozolomide, PTEN = phosphates and tensin homolog, EGFR = epidermal growth factor receptor, TCGA = the cancer genome atlas, IDH1/2 = isocitrate dehydrogenase 1 and 2.

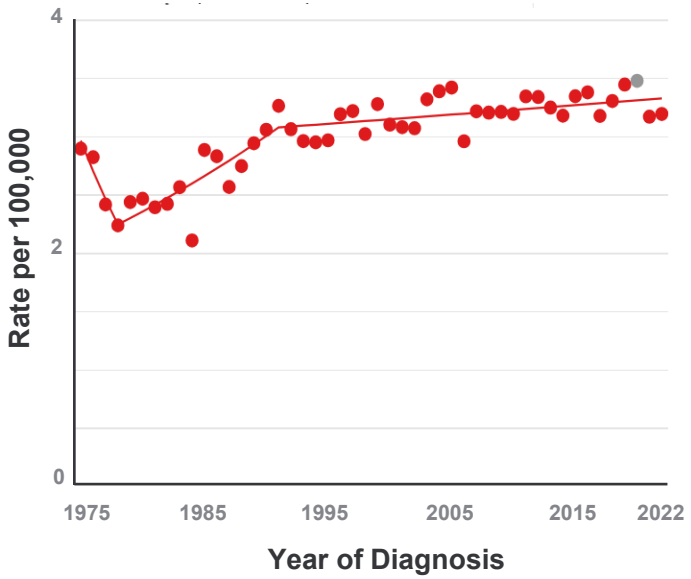
Disease overview: Glioblastoma (GBM)

Burden of GBM is increasing, however survival rates have not improved in 20+ years[1]

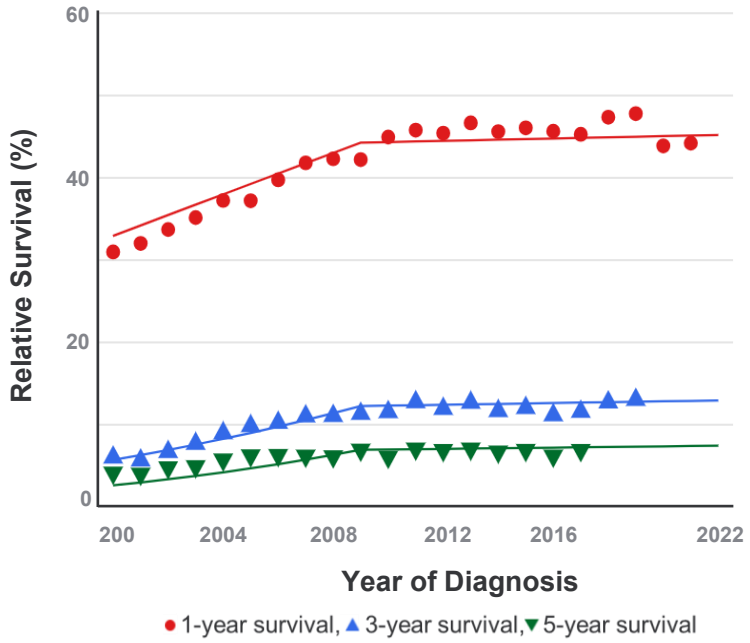
~25k new brain and CNS tumor cases/yr with **~18k** deaths/yr (U.S.)[1]

GBM is the most common and most aggressive type of brain cancer, accounting for **~50%** of all malignant CNS tumors or **~15k+** patients/year[2]

Annual incidence (US)[1]



Average survival (U.S.)[1]



Patients with GBM have a median overall survival of 12-15 months[1] from diagnosis and 3-9 months from recurrence[3]

CNS: central nervous system.

1. American Cancer Society (Cancer Facts & Figures 2025).
2. Grochans S, et al. *Cancers (Basel)*. 2022;14(10):2412.
3. Nahm et al. J Clin Oncol 41, e14057(2023).

Prior TLX101-Tx studies have demonstrated favorable safety profile and encouraging efficacy in malignant gliomas

Demonstrated safety and tolerability profile in combination trials with EBRT and TMZ

- IPAX-1 (Phase 1), IPAX Linz[1] (Phase 2), IPAX-2 (Phase 1), compassionate use program
- Treated ~60 patients to date, including pediatric patients[2]
- Well tolerated, no DLTs observed in IPAX-2[3]

Demonstrated early efficacy results

- Median OS of 23mo. (IPAX-1) and 32.2mo. (IPAX-Linz[1]) from initial diagnosis
- Median OS of 13mo. (from initiation of treatment, IPAX-1) and 11.9mo. (from progression prior to start of treatment, IPAX-Linz[1])

Ongoing trials

- Phase 3 trial, IPAX™ BrIGHT, in combination with lomustine, first recurrence – dosing patients
- Phase 1 trial, IPAX-2, in newly diagnosed patients – completed enrollment, awaiting readout

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1. Investigator-initiated trial referring to clinical study report (CSR), 2. Across various trials (IPAX-1, IPAX-Linz, IPAX-2, IPAX BrIGHT) and compassionate use program. 3. Telix media release May 19, 2026.

IPAX BrIGHT™, A global Phase 3 study for TLX101-Tx

Part 1: Dose optimization

TLX101-Tx (4 GBq) + Lomustine (90 mg/m²) x 3 cycles n = 3

→

TLX101-Tx (4 GBq) + Lomustine (90 mg/m²) x 3 cycles n = 12

→

If combination dose not tolerated, lower either TLX101-Tx dose and/or Lomustine. Mono therapy is an option
n = up to 50

Part 2: Randomized treatment expansion

Data review → 1:1

- **TLX101-Tx + Lomustine**
- **Lomustine**

Conventional MRI and ^{18}F FET PET used for imaging response

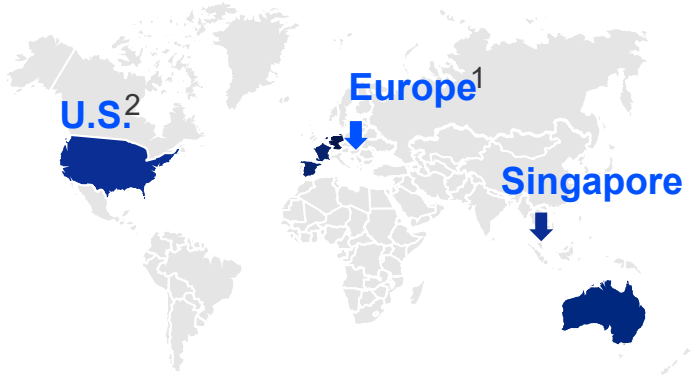
Primary endpoints (Part 1)

- Max tolerated dose, MTD and recommended dose for Part 2

Primary endpoint (Part 2)

- Overall survival (OS)

Global, multi center, prospective, open label study



Clinicaltrials.gov: NCT07100730

Eligibility: recurrent GBM (WHO 2021), 18 years+

Status: Study open to enrollment in Austria, Australia, Belgium and Netherlands. Regulatory authorizations to proceed in Denmark, France, Germany, Spain and Singapore. IND filed to expand the study to the U.S.

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1. Europe includes Austria, Belgium, Denmark, France, Germany, Netherlands, Spain where we have regulatory approvals or filings.
2. IND currently under review.

TLX101-Tx, has demonstrated a favorable safety profile, with stable disease observed

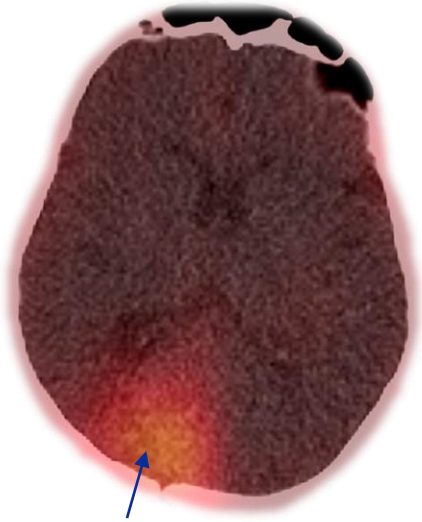
Demonstrated favorable safety and tolerability in compassionate use program[1]

- Grade 3 adverse events, cerebral edema (1), common for this condition, judged not likely due to TLX101-Tx
- No Grade 4 adverse events

Results of a cohort of 12 GBM, Oligodendroglioma and Astrocytoma brain tumors patients treated at a single center:

RANO Response Criteria	MRI RANO	PET RANO*
Stable disease (SD)	3 of 12	3 of 7
Partial Response (PR)	0 of 12	1 of 7
Progressive disease (PD)	9 of 12	3 of 7

*PET follow-up (^{18}F-Floretyrosine) only available in 7 of 12 patients



TLX101-Tx tumor uptake

Patient representative scans - individual results may vary.

Over 26 patients have been treated with TLX101-Tx in our compassionate use program in Austria, Australia, Germany, Netherlands, New Zealand and USA with no Grade 4 adverse events reported

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1. Named patient program, UMC Utrecht. Sturre TAJ et al IODO-RISE, presented at EANM 2026.

IPAX-2, Phase 1 study for TLX101-Tx (newly diagnosed GBM)

Met Primary endpoint: Max Tolerated Dose (MTD) of 5GBq x 2cycles + SoC achieved

Dose escalation

TLX101-Tx (3 GBq) x 2 cycles + SoC → **TLX101-Tx (4 GBq) x2 cycles + SoC** → **TLX101-Tx (5 GBq) x2 cycles + SoC**

SoC = Maximal safe resection followed by concomitant EBRT + TMZ and adjuvant TMZ

n = 12

Conventional MRI and [^{18}F]FET PET used for imaging

Eligibility: newly diagnosed glioblastoma patients[1]
Status: Study enrollment completed
Results: **no dose limiting toxicities observed at maximum dose of (5 GBq) x 2 cycles within DLT window (63 days)**
Next steps: **data supports advancement into Phase 2 study**

Primary endpoints

- Safety and tolerability
- Max tolerated dose and recommended dose

Global, multi center, open label, single arm study



Clinicaltrials.gov: NCT05450744

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SoC = standard of care. EBRT = external beam radiation therapy, TMZ = temozolomide.
1. Post surgical resection and prior to systemic therapy or radiation therapy for GBM.

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Renal cancer (select programs)

Dr. David N. Cade

Group Chief Medical Officer



Disease overview: Kidney cancer

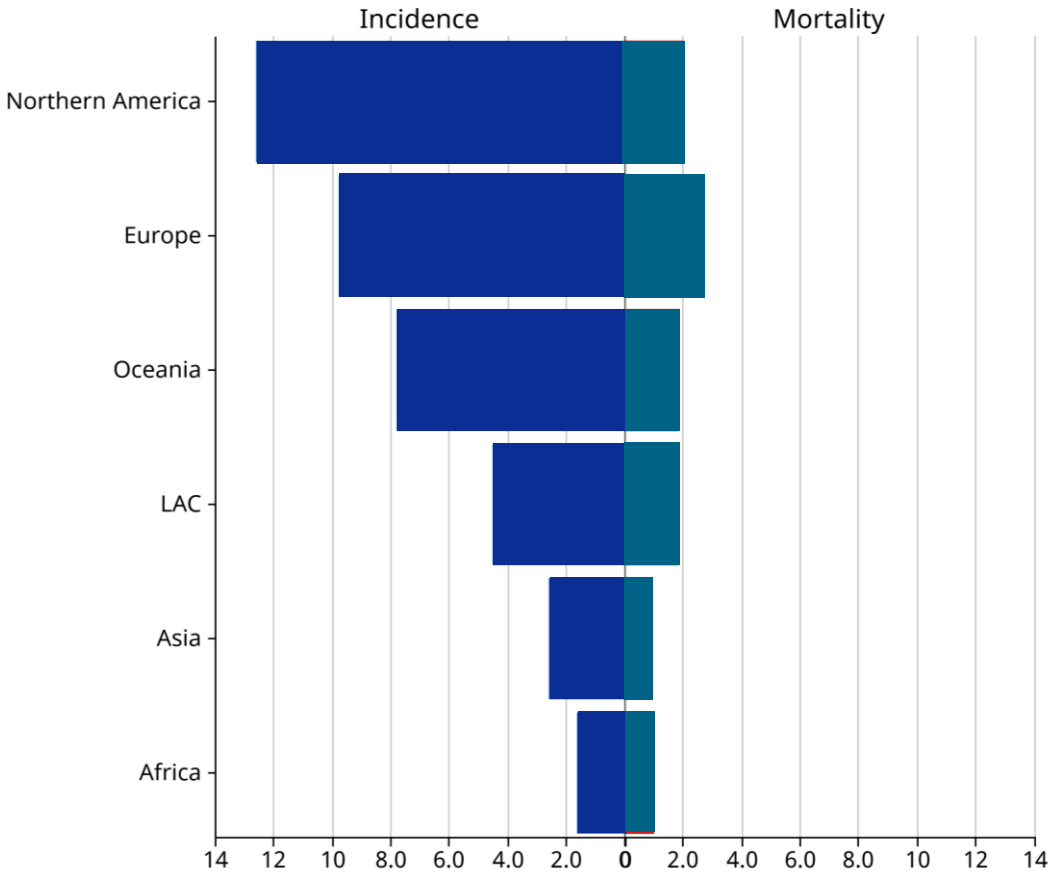
14th most commonly diagnosed cancer worldwide[1]

Age-standardized incidence & mortality highest in **North America & Europe**[1]

Twice as common in men vs women[1]

90% of kidney cancer is RCC, of which ~85% is ccRCC[2,3]

Age-standardized rate per 100,000 (2022)[4]



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ccRCC, clear cell renal cell carcinoma; RCC, renal cell carcinoma.

1. Bray F, et al. *CA Cancer J Clin*. 2024;74(3):229-263.
2. Qi X, et al. *Front Oncol*. 2021;11:727778.
3. Alchahin AM, et al. *Nat Commun*. 2022;13(1):5747.
4. Globocan 2022 (version 1.1) - 08.02.2024. https://gco.iarc.who.int.

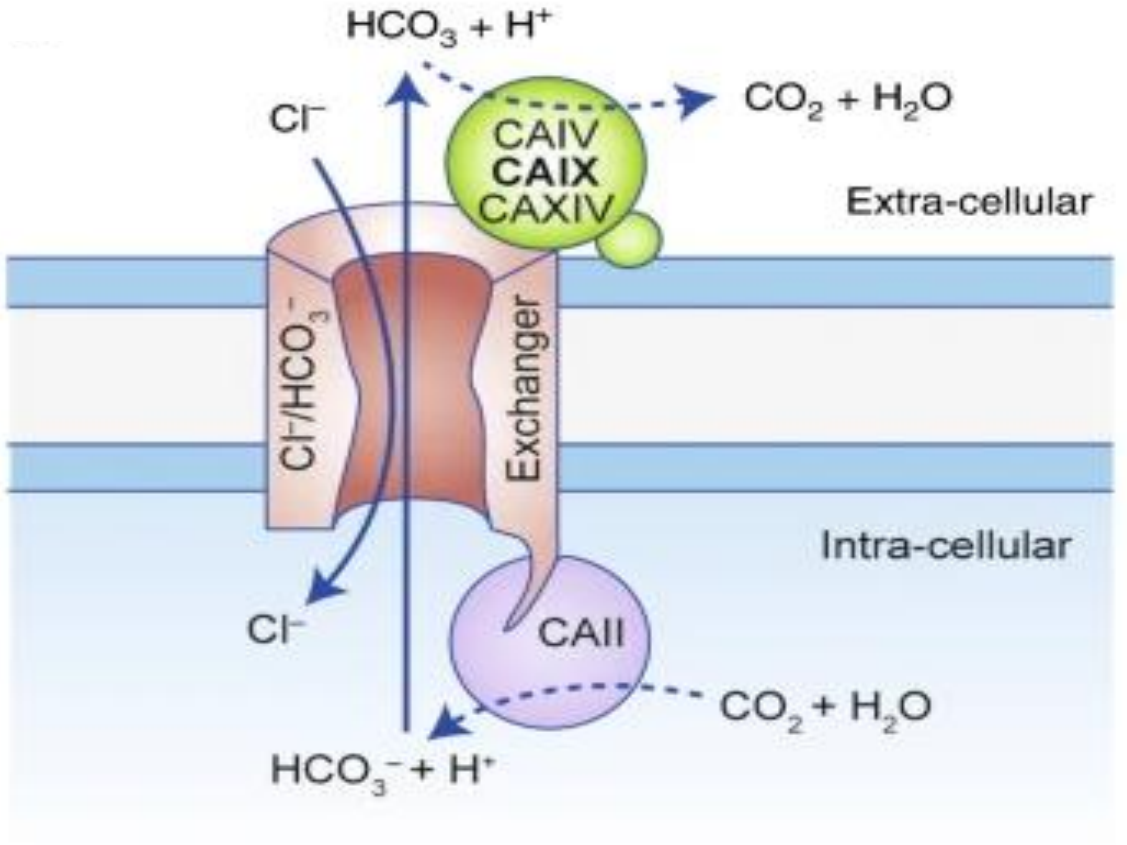
Novel target in ccRCC - CAIX

Transmembrane glycoprotein involved in oxygen-sensing pathways and regulator for pH[1,2]

Induced by hypoxia or by mutation of the Von Hippel-Lindau tumor suppressor gene[1-4]

Expressed in >95% of ccRCC[5-7]

Negligible expression in normal kidney tissue[7]



Adapted from Becker HG.[2]

1. CAIX, carbonic anhydrase IX; ccRCC, clear cell renal cell carcinoma.
2. 1. Aldera AP, et al. J Clin Pathol. 2021;74(6):350-354. 2. Becker HM. Br J Cancer. 2020;122(2):157-167. 3 3. Wykoff CC, et al. Cancer Res 2000;60(24):7075–7083. 4. Maxwell PH, et al. Nature 1999;399(6733):271–275. 5. Courcier J, et al. Int J Mol Sci 2020;21(19):7146. 6. Bui MHT, et al. Clin Cancer Res 2003;9(2):802– 811. 7. Stillebroer AB, et al. Eur Urol 2010;58(1):75–83.

Monoclonal antibody-based theranostics

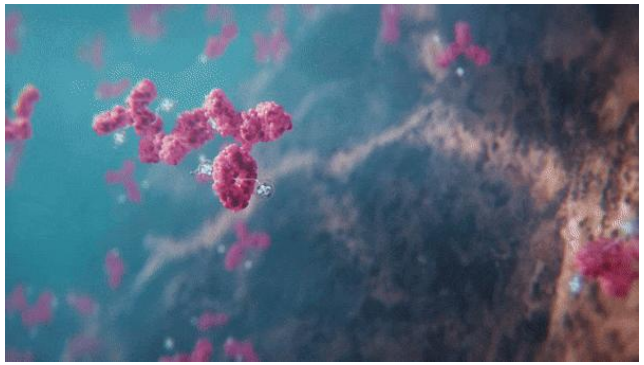
TLX250-Tx for treatment of ccRCC and TLX250-Px for imaging

Girentuximab

- IgG1 kappa light chain chimeric monoclonal antibody
- Girentuximab - highly specific binding to CAIX and internalization
- Safety data from Phase 1-3 clinical studies with girentuximab in RCC, including nearly 500 patients and healthy volunteers1-4
- Hepatic clearance

Payload: ^{89}Zr (imaging)

- Positron emitter
- Half-life 3.3 days
- Suitable for antibody-based PET imaging



Payload: ^{177}Lu (therapy)

- Medium-energy β-emitter
- Half-life 6.7 days
- Suitable for antibody-based therapy



CAIX, carbonic anhydrase IX; PET, positron emission tomography.

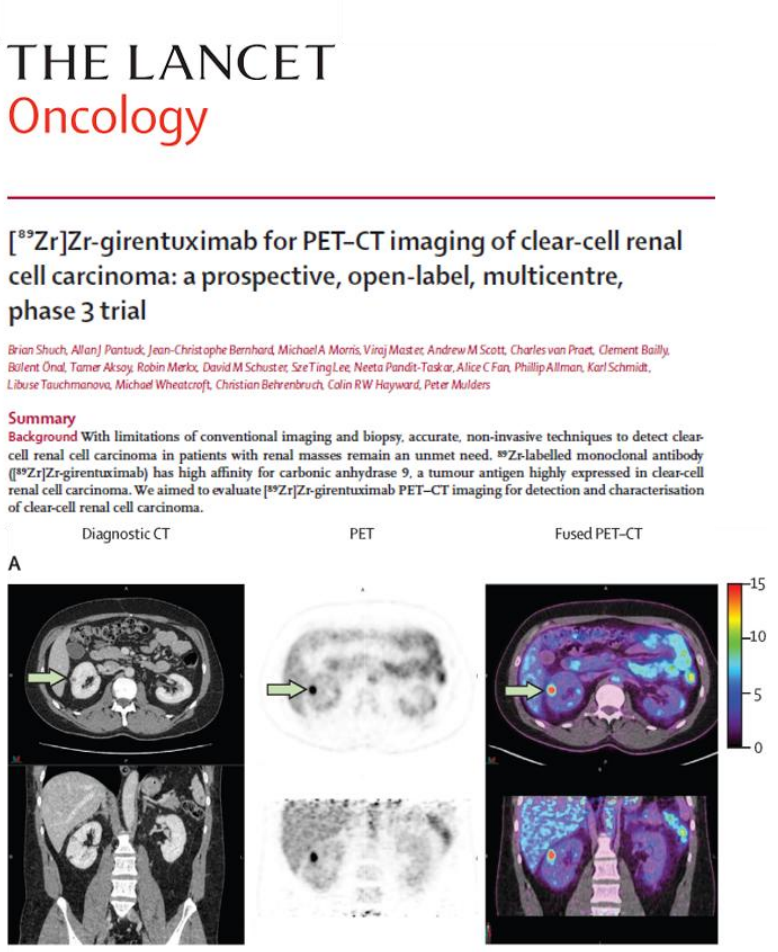
1. Oosterwijk-Wakka et al. Int J Mol Sci. 2013;14(6):11402-23; 2. Kulterer et al. J Nucl Med. 2021;62(3):360-5. 3. Merkx et al. Eur J Nucl Med Mol Imaging. 2021;48(10)3277-85 4. Chamie et al, 2-15.

TLX250-Px: ZIRCON imaging data validates target in ccRCC

Phase 3 imaging trial and real-world evidence have important insights for therapy program

ZIRCON study results summary

Primary endpoints: (n=284)	**Sensitivity: 86% | Specificity: 87%**
Sensitivity & specificity of small lesions	**≤4 cm (n=145)** • Sensitivity: 85% • Specificity: 90% **≤2 cm (n=20)** • Sensitivity: 97% • Specificity: 97%
Reader agreement	**The Fleiss' κ statistic for inter-reader variability:** 91% Cohen's κ statistic for intrareader **variability:** 100% for each reader
Safety & tolerability	**Favorable profile indicated**


THE LANCET
Oncology

[^{89}Zr]Zr-girentuximab for PET–CT imaging of clear-cell renal cell carcinoma: a prospective, open-label, multicentre, phase 3 trial

Brian Shuch, Allan J Pantuck, Jean-Christophe Bernhard, Michael A Morris, Viraj Master, Andrew M Scott, Charles van Praet, Clement Bailly, Bülent Önal, Tamer Aksoy, Robin Mørks, David M Schuster, Sze Ting Lee, Neeta Pandit-Taskar, Alice C Fan, Phillip Allman, Karl Schmidt, Libuse Tauchmanova, Michael Wheatcroft, Christian Behrenbruch, Colin RW Hayward, Peter Mulders

Summary

Background With limitations of conventional imaging and biopsy, accurate, non-invasive techniques to detect clear-cell renal cell carcinoma in patients with renal masses remain an unmet need. ^{89}Zr-labelled monoclonal antibody ([^{89}Zr]Zr-girentuximab) has high affinity for carbonic anhydrase 9, a tumour antigen highly expressed in clear-cell renal cell carcinoma. We aimed to evaluate [^{89}Zr]Zr-girentuximab PET–CT imaging for detection and characterisation of clear-cell renal cell carcinoma.

CAIX, carbonic anhydrase IX; ccRCC, clear cell renal cell carcinoma; mAb, monoclonal antibody; PET, positron emission tomography; rADC, radio antibody-drug conjugate; $T_{1/2}$, half-life.

Shuch B, et al. *Lancet Oncol*. 2024;25(10):1277-1287.

ZIRCON ClinicalTrials.gov ID: NCT03849118.

TLX250-Tx: LUTEON (Ph3) and LUTEON-ATLAS (Ph2a) trial design

US/EU: *LUTEON-ATLAS (Ph2a)* — U.S. sites enrolling patients / EU under review

AUS: *LUTEON (Ph3)* — AUS sites enrolling patients[1]

Population:

- Advanced or metastatic ccRCC
- Disease progression on/after 2 to 3 prior systemic lines of therapy
- CAIX-positive by ^{89}Zr-TLX250 PET

Safety Lead-in*

N=3

1,887 MBq

1,258 MBq

RP2a

DR1 = 20

DR2 = 20

1:1

N=3

Part 1: Dose Optimization (Phase 2a)

1887 MBq	1887 MBq	1887 MBq
1258 MBq	1258 MBq	1258 MBq
1258 MBq	1258 MBq	1258 MBq

1 | 2 | 3 | 4 | 5 | 6

Treatment period (months)

Dose administration

- 2-month intervals
- 1-month intervals

Part 2 (Phase 3)

N=TBD

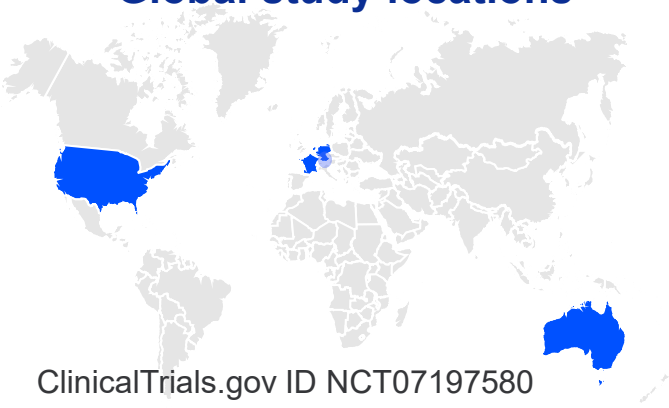
RP3D — 1:1

^{177}Lu-TLX250 (RP3D)

Investigators choice (SOC)

N=TBD

Global study locations[2]



*3 pts in Safety Lead-in included in total 20 pts in Part 1 (Dose Optimization); No Safety Lead-in in AUS

HREC = Human Research Ethics Committee, ccRCC = clear cell renal cell carcinoma, DR1 = Dosing regimen 1, DR2 = Dosing regimen 2, PET = positron emission tomography, R= randomization, RP3D = recommended Phase 3 dose, SoC = Standard of care.

1. ClinicalTrials.gov ID NCT07197580, Telix media release July 21, 2026. 2. Australia: recruiting, U.S.: recruiting, Europe: application under review.

ClinicalTrials.gov ID NCT07197580

Telix

TLX591-Tx

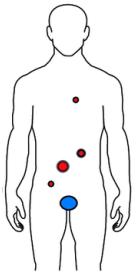
Dr. David N. Cade

Group Chief Medical Officer, CMO

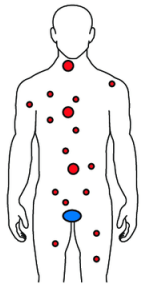


Disease progression shifts clinical priorities

Distinct prostate cancer disease states bear implications for patient management



Androgen pathway modulator sensitive → **Androgen pathway modulator resistant**



	Androgen pathway modulator sensitive	Androgen pathway modulator resistant
Prognosis and patient profile	• Survival commonly extends beyond 4-5 years[1], generally fitter patients	• Approximately 2-3 years from initiation of 1L therapy[2], greater clinical complexity
Disease biology	• Variable tumor burden, more localized • Responsive to androgen suppression	• Increasing tumor burden • Progressively resistant phenotypes
Clinical implication	• Intensify treatment to delay progression to mAPMR • Preserve long-term quality of life	• Optimize sequencing across limited options • Maximize efficacy at each treatment line

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SOURCES:
1. Kyriakopoulos et al. J Clin Oncol. 2018, Fizazi et al. *Lancet Oncol.* 2019
2. Armstrong et al. Eur Urol. 2020; Ryan et al. Lancet Oncol. 2015

mAPMR: metastatic androgen pathway modulator-resistant.
NOTE: Illustrative ranges; outcomes vary by disease volume, prior treatment, patient characteristics and therapy.

Addressing patient needs across the care continuum

TLX597-Tx and TLX591-Tx profiles are adapted to each disease state

	TLX597-Tx: Next gen small molecule[1]	TLX591-Tx: First-in-class rADC[2]
Excretion organ	• Renal excretion BUT with 1/3rd radiation dose to kidney vs PSMA-617	• Liver excretion (radio-tolerant organ) with minimal dose to kidneys
Kidney and salivary gland impact	• Limited kidney dose, radiation to salivary gland 1/5th vs PSMA-617	• Limited kidney dose and negligeable salivary gland uptake
Efficacy signal	• High lesion dosimetry, positive signals from OPTIMAL-PSMA and PTherpan-Lu	• rPFS of 8.8 months in ProstACT SELECT trial
Dosing	• 3-7 doses of 230mCi adaptively administered to limit overtreatment	• 2 doses of 76 mCi enables combination with mAPMR SOC (ARPI and chemo)
	mAPMN/S	**mAPMR**

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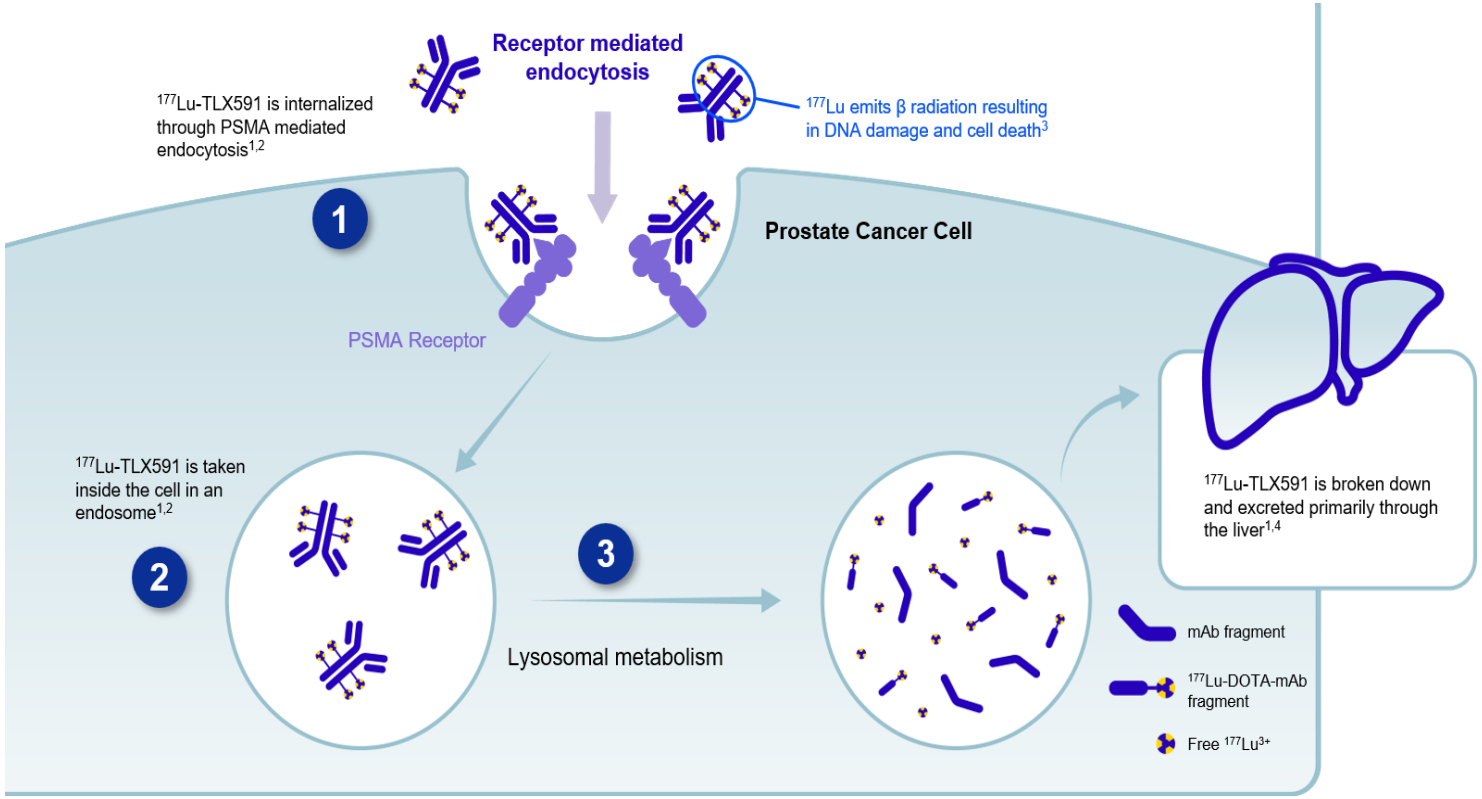
1. Kahn at al. *Dose Optimisation and PSMA Receptor intensification with 177Lu-PSMA-597 in metastatic castration-resistant prostate cancer, the Randomised Phase II OPTIMAL-PSMA trial*, presented at IPCS / APCCC 2026; Omar et al, *[177Lu]Lu-DOTA-HYNIC-panPSMA radioligand therapy for patients with metastatic castration-resistant prostate cancer*, presented at EANM 2025
2. Sartor et al. Presented at: American Society of Clinical Oncology Annual Meeting 2024; TPS5115; Sun et al. *Curr Oncol Rep.* 2021; Lenzo et al. *Cancers (Basel)*. 2026; Tagawa ST, et al. *Cancer.* 2019.

TLX591-Tx is a novel therapy candidate for prostate cancer

Radio antibody-drug conjugate (rADC) approach addresses key unmet needs[1-4]

1. **Patient friendly 2-dose / 2-week regimen:** Supports compliance to treatment and ease of integration with standard of care (SOC)
2. **Safety and tolerability profile:** Low radiation to salivary glands and kidneys, transient and manageable hematologic profile
3. **Internalization and prolonged retention:** Delivering a payload to the tumor, potentially maximizing cell killing effect
4. **Supply, access, and radiation protection:** Potential real-world advantages from lower administered activity (76 mCi per dose)

Mechanism of Action



1. Sartor O, et al. Presented at: American Society of Clinical Oncology Annual Meeting 2024; TPS5115.
2. Sun M, et al. *Curr Oncol Rep.* 2021.
3. Lenzo et al. *Cancers (Basel)* 2026.
4. Tagawa ST, et al. *Cancer.* 2019.

Phase 3 study for TLX591-Tx

Part 1 completed, with FDA alignment to advance to Part 2 in U.S.[1]

Part 1: Safety and dosimetry: completed

- TLX591-Tx (76mCi) x 2 cycles + abiraterone n = 10
- TLX591-Tx (76mCi) x 2 cycles + enzalutamide n = 10
- TLX591-Tx (76mCi) x 2 cycles + docetaxel n = 10

n = 30

Data review

Part 2: Randomized treatment expansion

2:1

- TLX591-Tx + abiraterone/ enzalutamide/ docetaxel
- abiraterone enzalutamide docetaxel

n = ~490

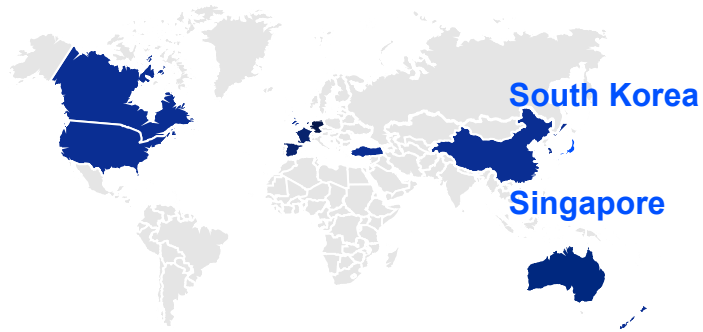
Primary endpoints (Part 1)

- Safety and dosimetry

Primary endpoint (Part 2)

- rPFS[6] by BICR[7]

Global, multi center, open label study



Eligibility: mAPMR[2] patients progressing on first ARPI
Status: Enrolling patients in Part 2 globally[8] (Japan approved for Part 1)

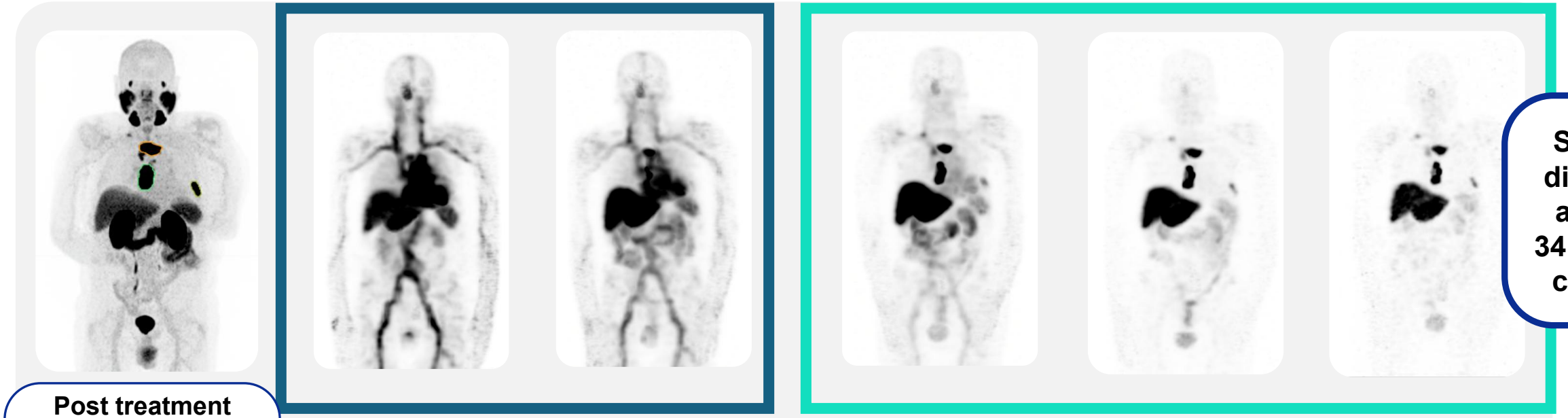
1. Following FDA review and alignment of the Part 1 safety data, Telix is finalizing its IND amendment to support progression to Part 2 of the ProstACT Global Phase 3 study in the U.S. 2. Metastatic androgen pathway modulation resistant prostate cancer. 3. Safety & tolerability reported as adverse events. 4. Independent Data Monitoring Committee review, October 2025. 5. Japanese regulator has granted approval for a Japan-specific Part 1 in nine patients, prior to commencing Part 2. 6. Radiographic progression-free survival. 7. Blinded independent central review. 8. Australia, New Zealand, Canada, Singapore, South Korea, Türkiye and UK.

Clinicaltrials.gov: NCT06520345

Patient case: TLX591-Tx (2 doses) + docetaxel (6 cycles)

83-year-old patient with bony metastatic lesions[1]

SPECT TLX591-Tx biodistribution: Single dose **Distribution of TLX591-Tx over 15 days[2]**



Post treatment SPECT imaging after one injection of TLX591-Tx

TLX591-Tx seen in the vascular space and liver

TLX591-Tx seen at metastatic sites (and liver)

Stable disease at day 341 (data cutoff)

BASELINE PET	4 hours	1 day	4 days	7 days	15 days*

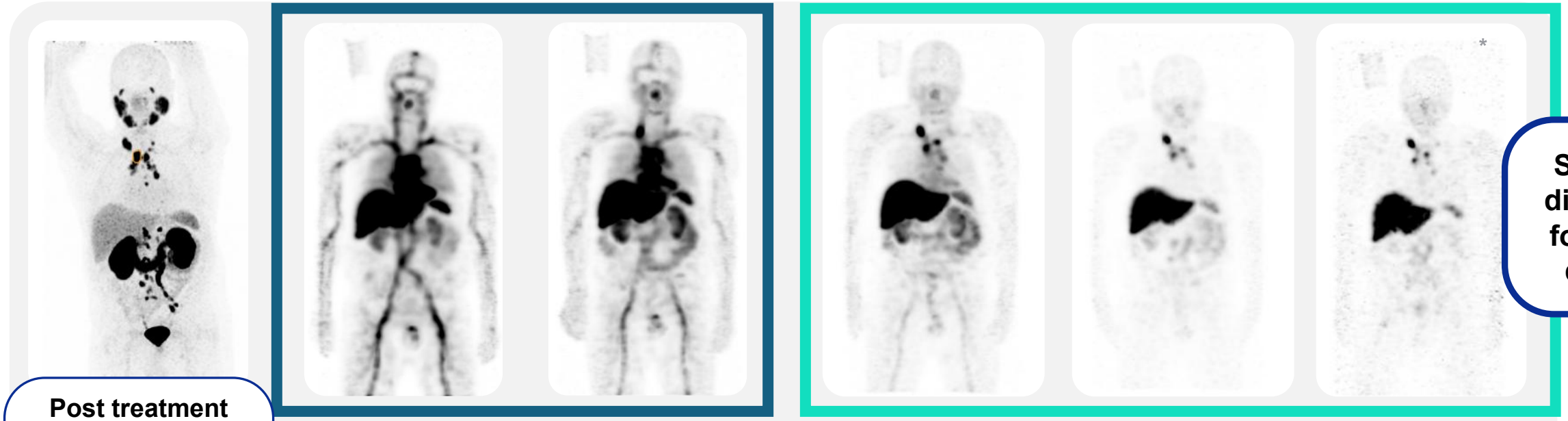
1. Thoracic vertebrae, ribs.
2. ProstACT Global Part 1 data on file. Telix Pharmaceuticals.

Patient representative scans – individual results may vary. Images are non-quantitative.

Patient case: TLX591-Tx (2 doses) + abiraterone

64-year-old patient with metastatic disease in lymph nodes[1]

SPECT TLX591-Tx biodistribution: Single dose distribution of TLX591-Tx over 15 days



Post treatment SPECT imaging after one injection of TLX591-Tx

TLX591-Tx seen in the vascular space and liver

TLX591-Tx seen at metastatic sites (and liver)

Stable disease for 339 days

BASELINE PET	4 hours	1 day	4 days	7 days	15 days*

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TLX591-Tx, ^{177}Lu-rosopatamab

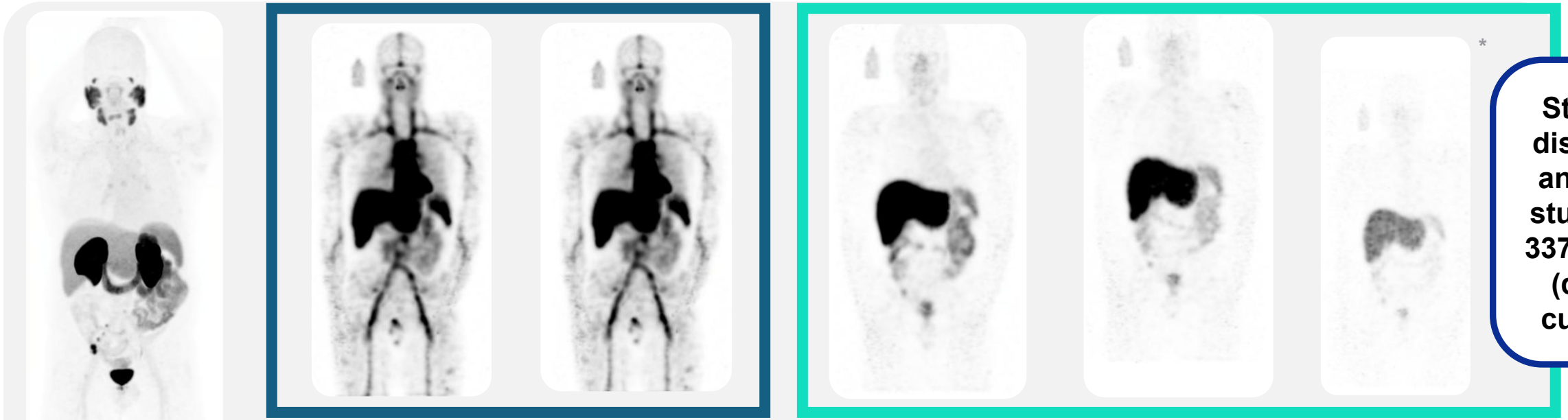
1. Subcarinal, right upper para-tracheal, abdominal, pelvic lymph nodes.

Patient representative scans – individual results may vary. Images are non-quantitative.

Patient case: TLX591-Tx (2 doses) + enzalutamide

62 year-old patient with prior ARPI (darolutamide) and docetaxel[1]

SPECT TLX591-Tx biodistribution: Single dose distribution of TLX591-Tx over 15 days



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TLX591-Tx, ^{177}Lu-rosopatamab

1. Subcarinal, right upper para-tracheal, abdominal, pelvic lymph nodes.

Patient representative scans – individual results may vary. Images are non-quantitative.

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TLX597-Tx



Prof. Louise Emmett

Director of Theranostics and Nuclear Medicine

St Vincent's Hospital Sydney

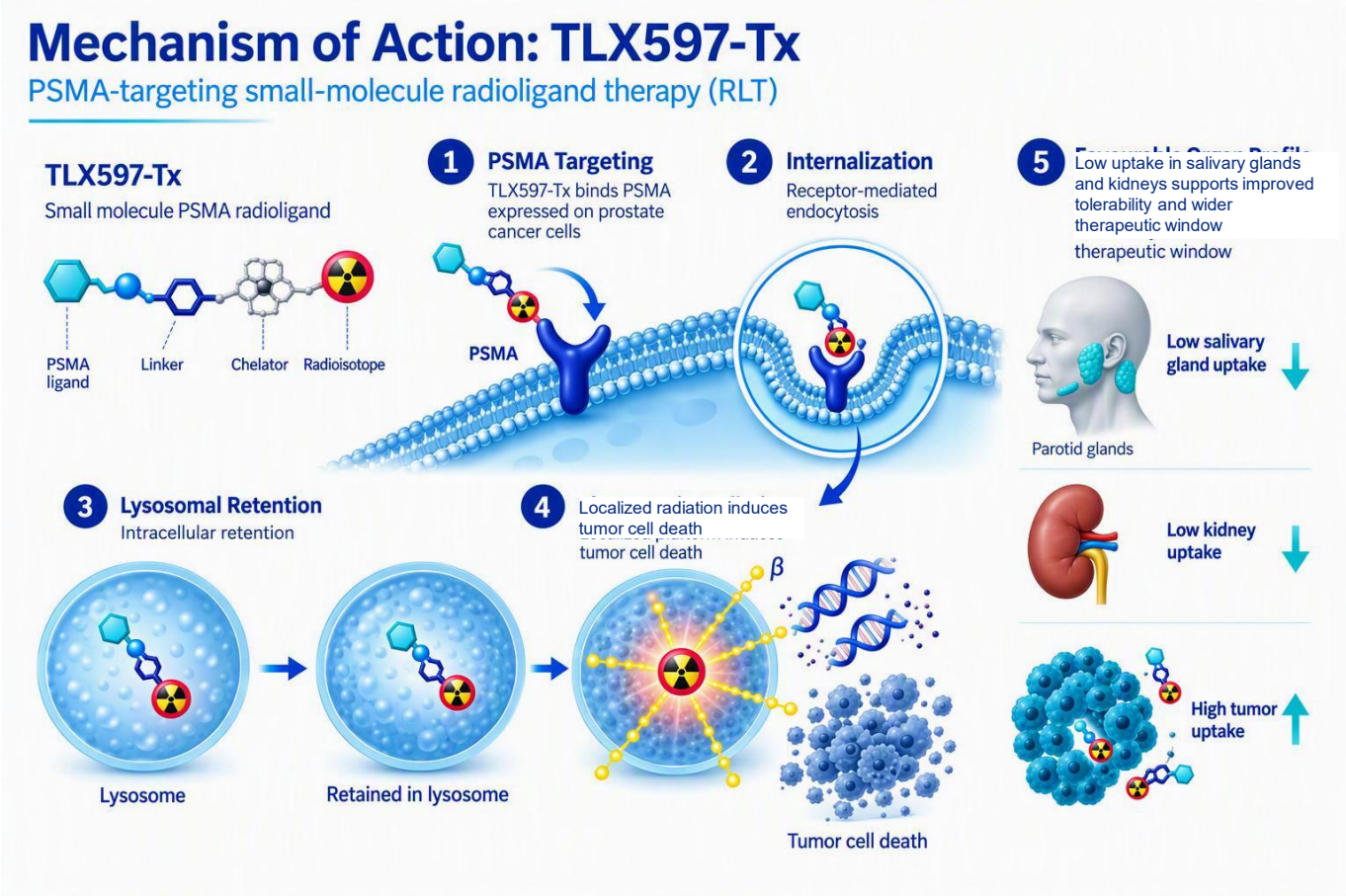
TLX597-Tx: Next-Generation PSMA-targeting RLT

Targeted mechanism supports enhanced tumor selectivity

TLX597-Tx, small molecule candidate with promising early safety and dosimetry data[1]

Key differentiators

1. Small-molecule PSMA ligand
2. High tumor uptake and retention[2]
3. Low salivary gland uptake[2]
4. Low kidney uptake[2]
5. Potential for dose intensification[3]



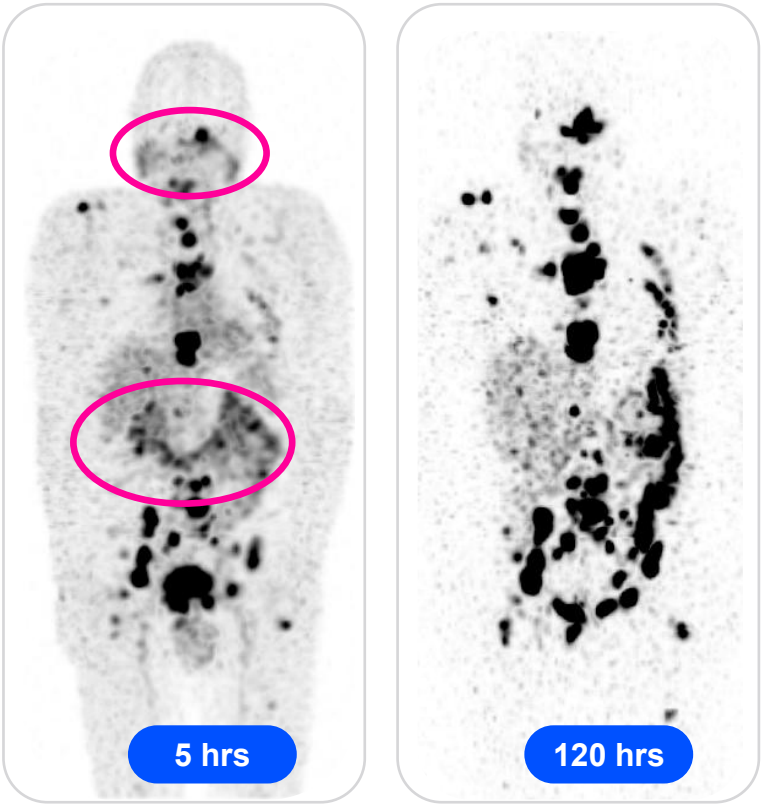
1. Steinhelfer et al. J Nucl Med. 2024.
2. Final dosimetry report for PSMA-597 (Ascinta Technologies).
3. Crumbaker at al. *Dose Optimisation and PSMA Receptor intensification with 177Lu-PSMA-597 in metastatic castration resistant prostate cancer, the Randomized Phase II OPTIMAL-PSMA trial*, presented at ASCO GU 2026.

TLX597-Tx early data suggests favorable dosimetry profile

Selective tumor targeting with lower healthy tissue exposure

Gy/GBq	TLX597-Tx (n = 12)[1]		PSMA-617[2] (n = 297)	PSMA-I&T[2] (n = 153)
Kidneys	**0.28**	<	0.58	0.71
Lacrimals	**0.35**	<	1.58	2.83
Submandibular	**0.25**	<	0.74	0.64
Lesions (bone)	**9.74**	>	3.57	4.1
Lesions (soft tissue)	**9.57**	>	4.19	2.94

TLX597-Tx SPECT scan, 5 hrs and 120 hrs



Patient representative scans – individual results may vary.

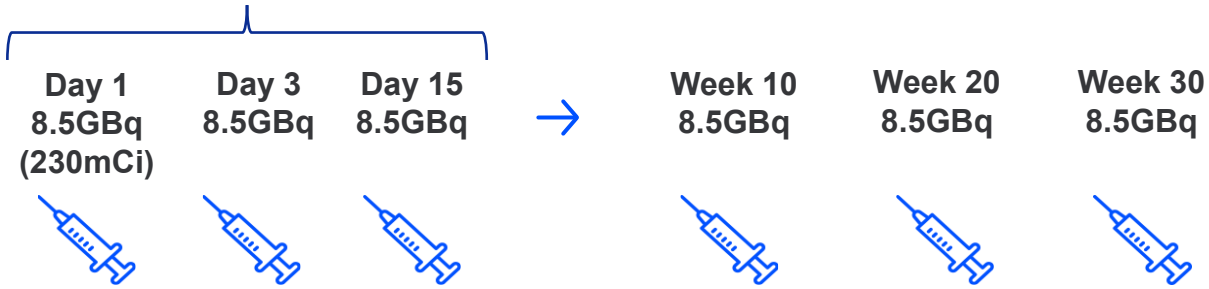
1. Khan et al. *J Nucl Med.* 2026. Final dosimetry report for PSMA-597 (Ascinta Technologies).
2. Ells et al Dosimetry of [177Lu]Lu-PSMA–Targeted Radiopharmaceutical Therapies in Patients with Prostate Cancer: A Comparative Systematic Review and Meta analysis. JNM 2024; 65:1264–1271.

Leveraging dose intensification and higher activity to enhance tumor response

Dose intensification consists of 2 components

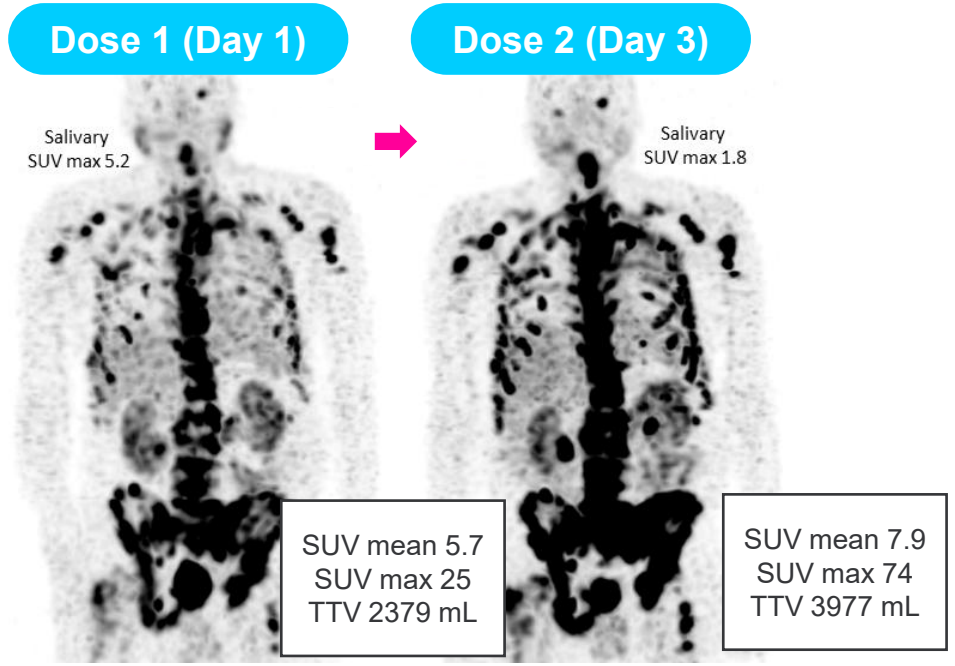
1 **First 3 doses administered** in 15 days

2 **Higher administered activity** of 8.5GBq/dose vs 7.5GBq



Dose intensification and higher activity are enabled by a favorable safety profile and biodistribution

PSMA up-regulation can be seen 3 days after the initial dose through higher TTV



Patient representative scans - individual results may vary.

The rationale is to exploit upregulated PSMA expression and incomplete tumor DNA repair

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1. Crumbaker at al. *Dose Optimisation and PSMA Receptor intensification with 177Lu-PSMA-597 in metastatic castration-resistant prostate cancer, the Randomized Phase II OPTIMAL-PSMA trial*, presented at ASCO GU 2026.

TLX597-Tx, Phase 2 OPTIMAL-PSMA study

Exploring safety and efficacy of dose intensification vs standard treatment

PSA response as well understood surrogate biomarker for small molecules (not for mAbs)

Part B

Majority of patients received prior taxane

Eligibility

- Confirmed mAPMR
- Progressed on prior ARPI
- Baseline ^{68}Ga-PSMA-11 **ENZA-p criteria (SUV max >15 at single site and >10 at larger sites)**

Investigator Initiated Trial (PI: Prof Louise Emmett, St Vincent's Hospital, Sydney)

2:1

TLX597-Tx* Dose Intensified

n = 80

TLX597-Tx Standard of Care

n = 40

n= 120

Initial 3 doses in 15 days

Last 3 doses every 10 weeks

Day 1 8.5GBq (230mCi)	Day 3 8.5GBq	Day 15 8.5GBq	Week 10 8.5GBq	Week 20 8.5GBq	Week 30 8.5GBq
Day 1 7.5GBq (200mCi)	Week 6 7.5GBq	Week 12 7.5GBq	Week 18 7.5GBq	Week 24 7.5GBq	Week 30 7.5GBq

^{68}Ga-PSMA-11 PSA at week 8 in both arms

30 weeks of treatment in both arms

6 doses every 6 weeks

Primary Endpoints

- PSA90 RR

Secondary Endpoints

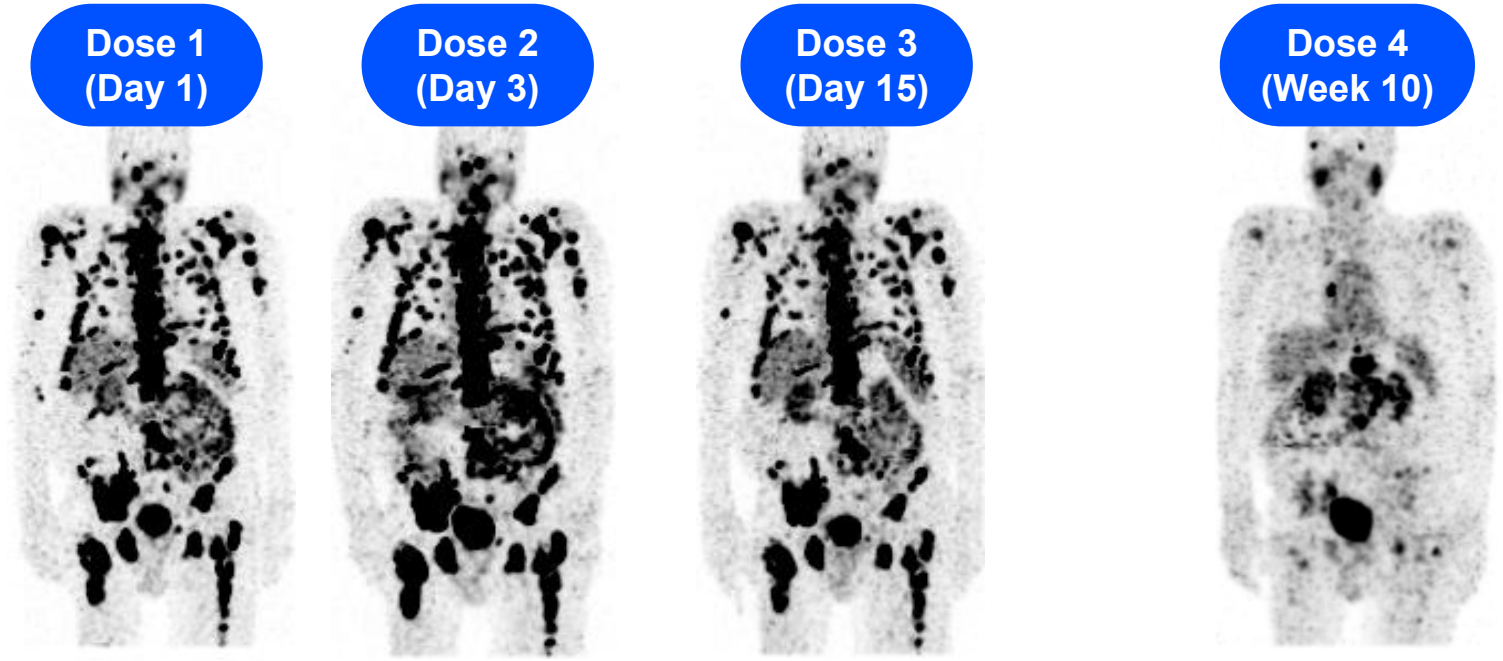
- PSA50 RR
- PSA-PFS
- rPFS
- OS
- ORR
- QoL
- Safety

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ANZCTR Registration Number: ACTRN12625000971437.

1. Pathmanandavel S, et al. *J Nucl Med*. 2022;63:1343-1351.
2. John N, Pathmanandavel S, et al. *J Nucl Med*. 2022;64:410-415.
3. Sheehan B, et al. *Clin Cancer Res*. 2022;28:3104-3115.

Patient case:
TLX597-Tx treatment post-chemo (2 lines) and ARPI



71-year-old patient with diffuse bone metastases

- Normal kidney function
- Substantial shrinkage of lesions
- **97% PSA response at week 10**

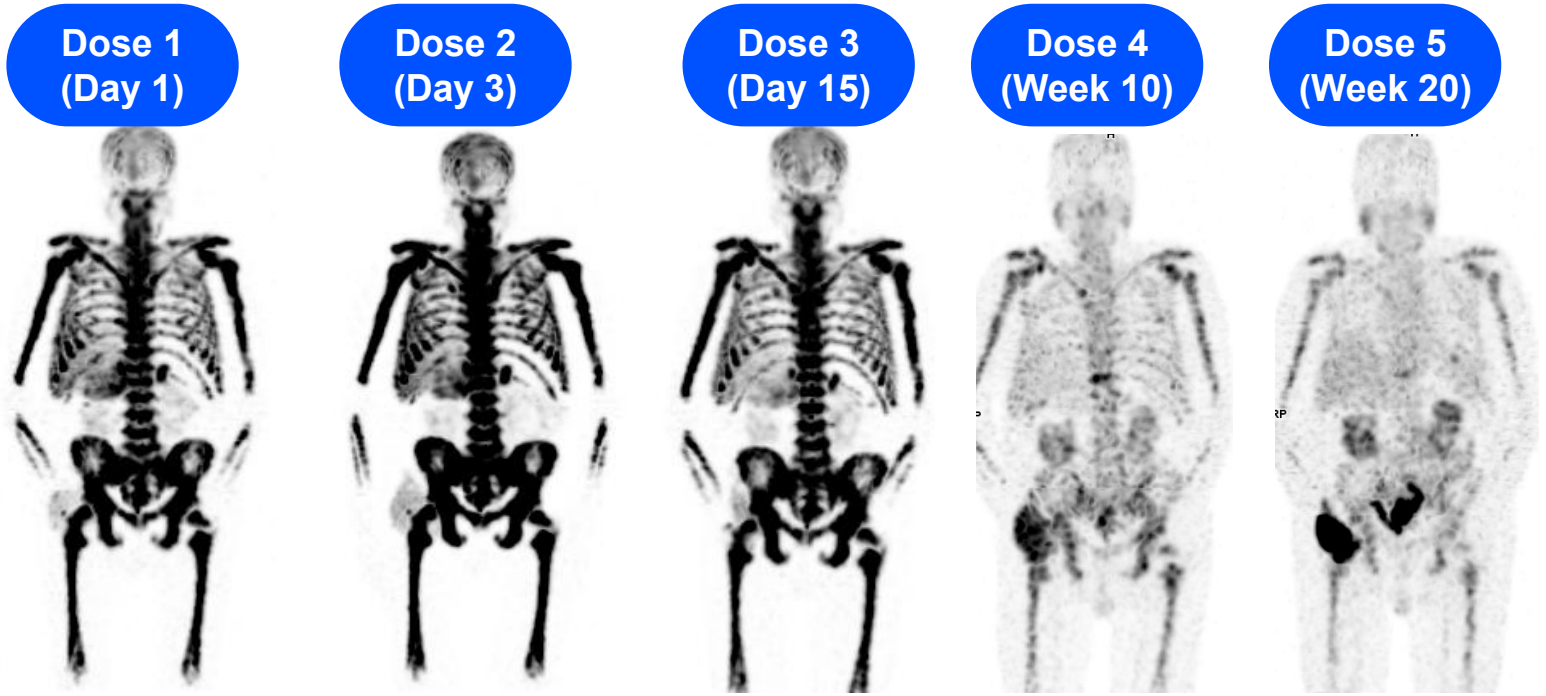
	Day 1	Day 3	Day 15	Week 6	Week 10
PSA	1,380	1,480	828	131	40
Hb	112	111	117	116	106
PLT	201	198	217	190	208
eGFR	90	90	90	90	89

Patient representative scans - individual results may vary.

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NOTES:
Hb: hemoglobin. PLT: Platelets. eGFR: estimated glomerular filtration rate (renal function).
Source: Data on file, L. Emmett.

Patient case: TLX597-Tx in advanced setting



Extensive skeletal / bone marrow involvement at baseline

- Improvement in hemoglobin
- Normal kidney function
- **99% PSA response**

	Day 1	Day 3	Day 15	Week 10	Week 20
PSA	487	522	358	27	1.9
Hb	81	77	113	67	106
PLT	130	123	109	130	244
eGFR	77	75	81	85	83

Patient representative scans - individual results may vary.

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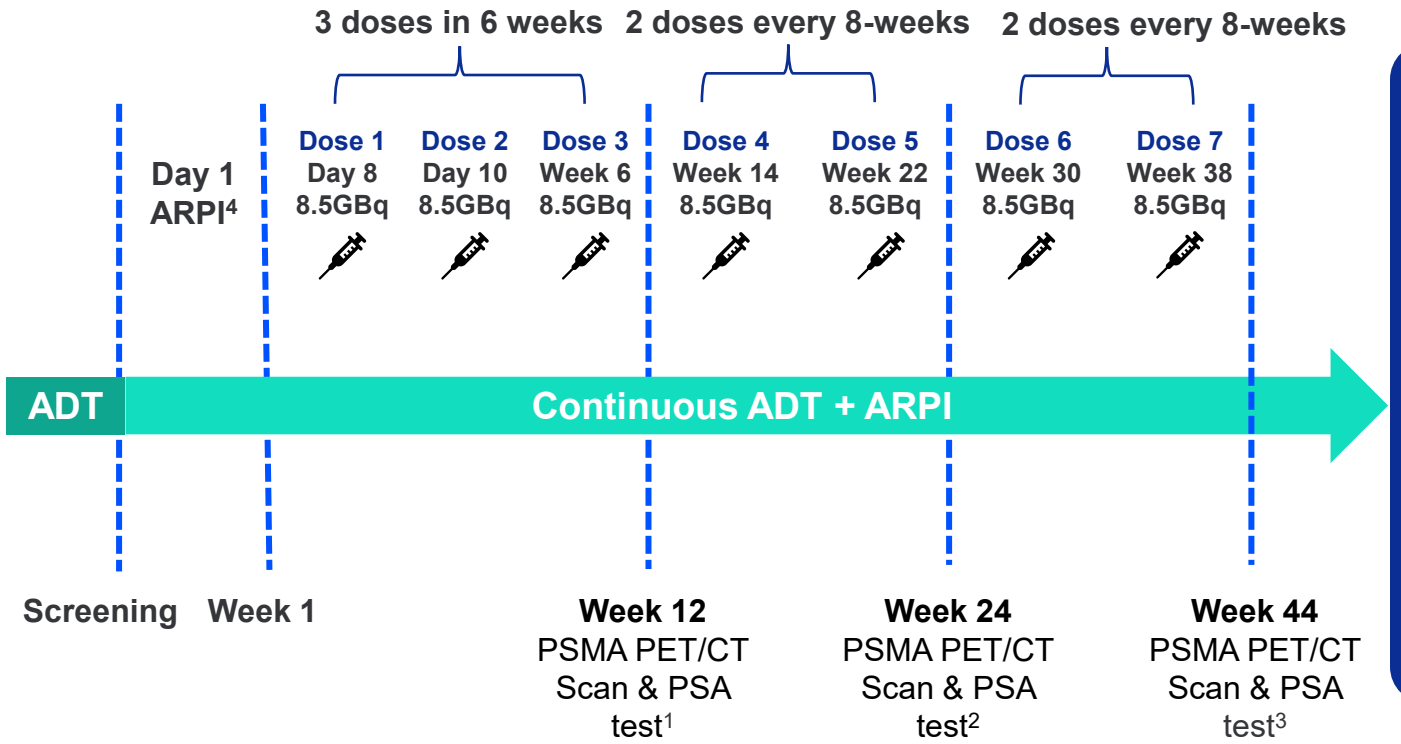
NOTES:
Hb: hemoglobin, PLT: Platelets, eGFR: estimated glomerular filtration rate (renal function). Advanced setting refer to disease progression post ARPI, received chemotherapy/medically unfit to receive chemotherapy.
Source: Data on file, L. Emmett.

TLX597-Tx, Phase 2 OPTIMAL-e study in mAPMN/S (mHSPC)

Adaptive PSMA targeted radioligand therapy

Eligibility

- Minimally treated mAPMN/S
- High risk metachronous / synchronous
- ADT < 30 days
- Baseline PSMA-PET using VISION Criteria



Primary endpoint

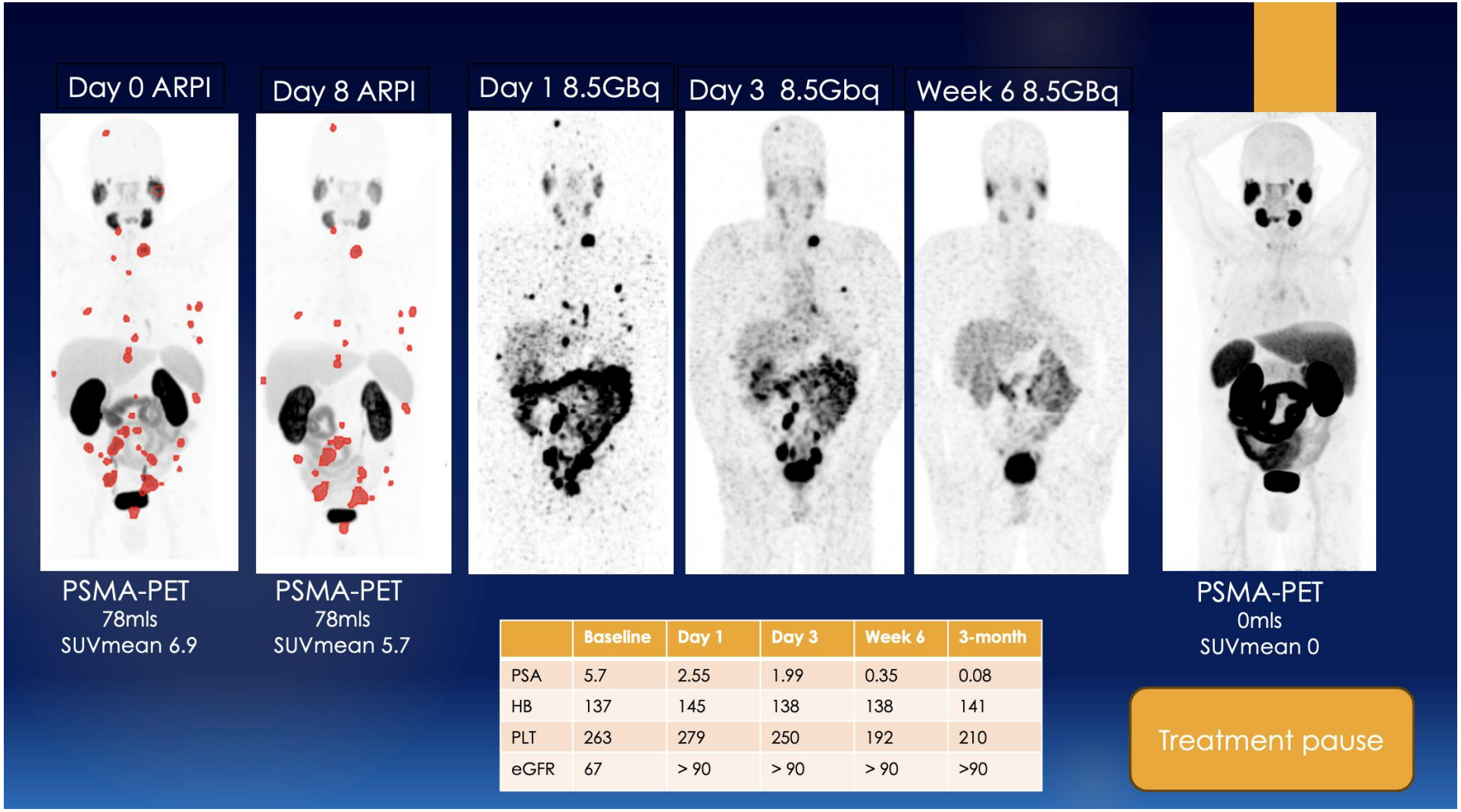
- PSA <0.2ng/mL at 6mo.

Secondary endpoints

- Safety
- PSMA PET response
- PSA 50% & 90% RR
- ORR
- QoL
- Dosimetry

1. After Dose 3, treatment pause is allowed in participants with >90% reduction in volume, no residual large lesions and no new lesions and PSA < 1ng/mL, or in participants with residual PSMA avid disease confined to the prostate only who then receive prostate radiotherapy). 2. After Dose 5, participants who have not had a [177Lu]Lu-PSMA-597 treatment-pause, have a PSA < 1ng/mL, and a >90% reduction in volume, no residual large lesions and no new lesions on the 24-week PSMA PET/CT, will be eligible for a treatment pause. 3. Following 7 doses, an additional 3 doses (7+3) of [177Lu]Lu-PSMA-597 can be given in responding participants at the discretion of the treating investigator. 4. abiraterone, apalutamide, darolutamide, enzalutamide.

Case study: OPTIMAL-e



	Baseline	Day 1	Day 3	Week 6	3-month
PSA	5.7	2.55	1.99	0.35	0.08
HB	137	145	138	138	141
PLT	263	279	250	192	210
eGFR	67	> 90	> 90	> 90	>90

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Patient representative scans - individual results may vary.
Source: Emmett, L. Next-generation PSMA therapeutics: The OPTIMAL trial experience, presented at EANM 2026, used with permission.

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Prostate cancer

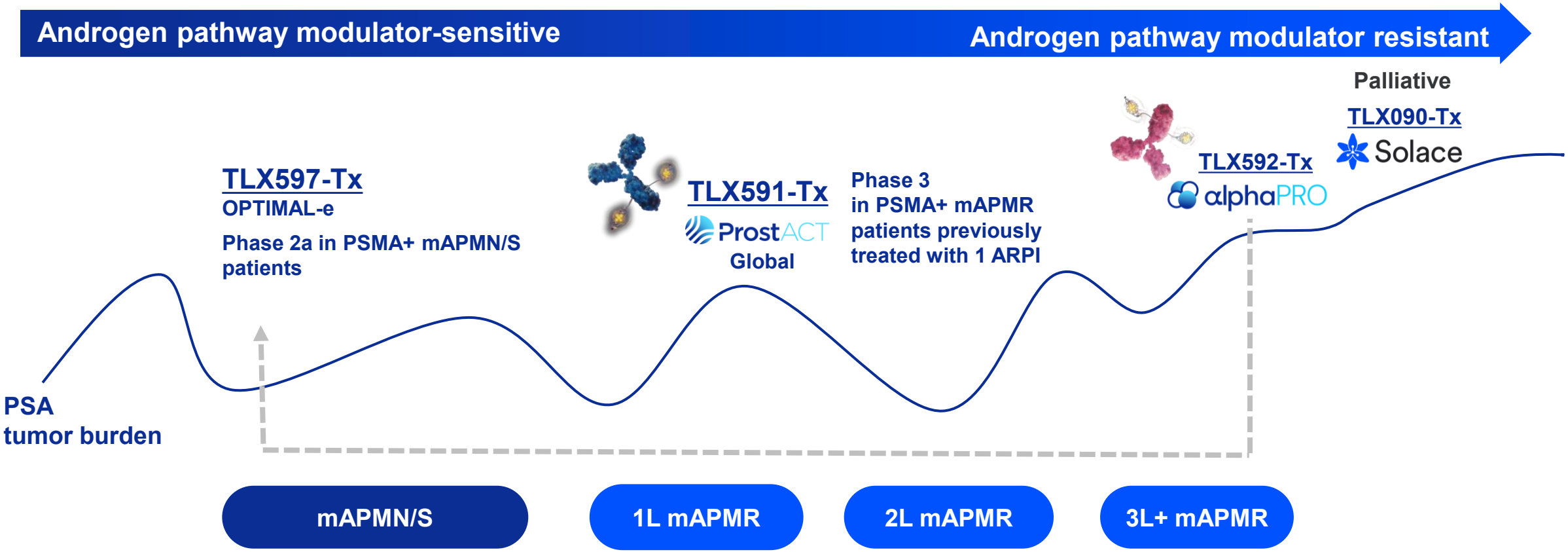
Dr. David N. Cade

Group Chief Medical Officer, CMO



Multi-product therapy portfolio in prostate cancer

Aligned to disease state, patient needs and clinical opportunity



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mAPMN/S = metastatic androgen pathway modulation naïve/sensitive; mAPMR = metastatic androgen pathway modulation resistant.

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Financial overview

Darren Smith
Chief Financial Officer



Financial strength creates strategic choice

A scaled commercial base enables strategic investment for long term value creation

2026 REVENUE GUIDANCE	PRECISION MEDICINE GROSS MARGIN	NET PROFIT AFTER TAX	CASH BALANCE
US$950–970M[1]	65%[2]	US$38M[2]	US$252M[3]

1

Commercial scale

Commercial execution of Precision Medicine and Therapeutics businesses diversifies revenue and generates cash

2

Strategic optionality and disciplined investment

Commercial success unlocks optionality – flexibility across late-stage pipeline, infrastructure and M&A

3

Vertical integration strengthens financial position

Control of critical supply chain reduces risk and improves profitability

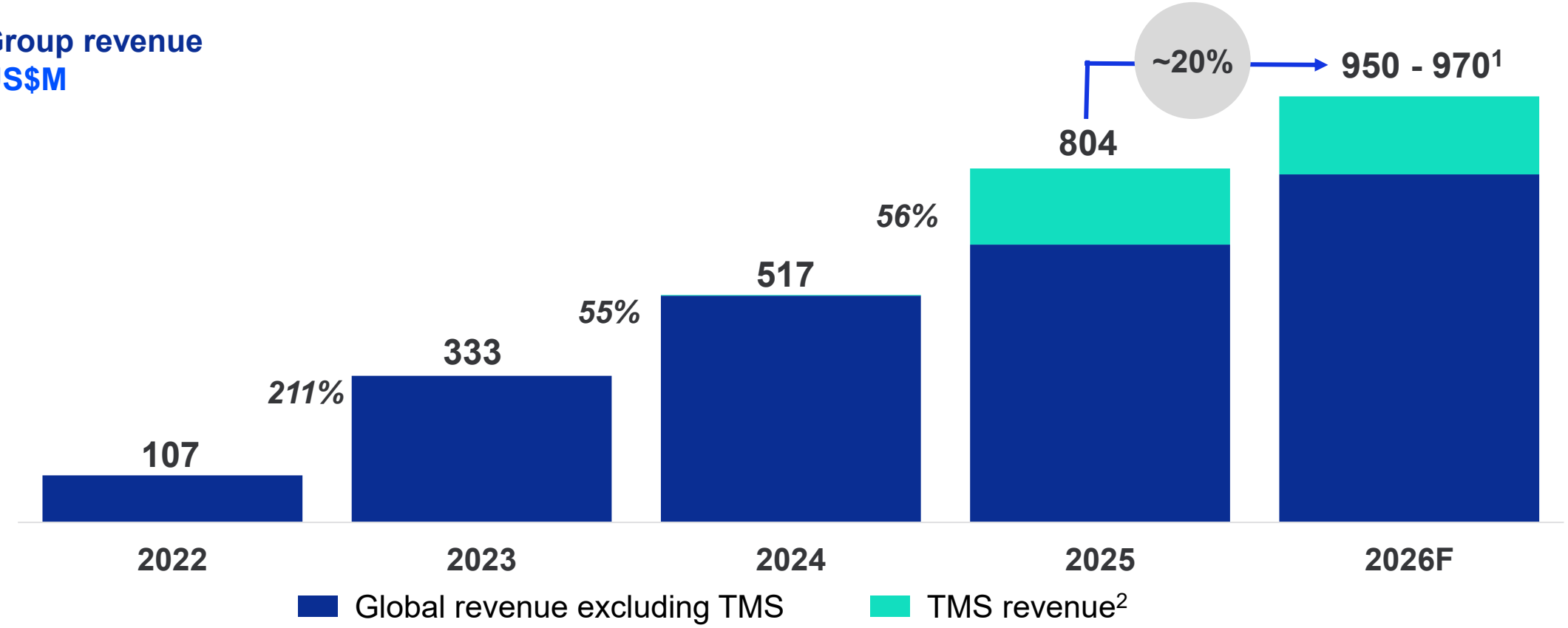
Commercial scale | Profitability | Investment ▶ Long term value creation

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1. First instance of guidance provided in ASX release February 20, 2026, reaffirmed in ASX release October 21, 2026. 2. H1 2026 results ASX release August 20, 2026.
3. As of June 30, 2026. ASX release August 20, 2026.

Consistent commercial execution driving sustained growth

Group revenue
US$M



TMS = Telix Manufacturing Solutions.
1. Refers to revenue guidance of $950M - $970M for FY2026 and $40M (Other Income), Telix ASX disclosure October 21, 2026. Year over year growth based on upper end of guidance.
2. TMS revenue from third parties. RLS is the largest component of TMS, contributing to third party revenue. Excludes revenues from Illuccix and Gozellix sold through RLS.

Disciplined capital allocation for sustainable growth

Commercial investments

Optimize sales performance, globally

R&D investments

Investment in the therapeutics and precision medicine pipeline

Capital allocation

Supply resilience

Supply chain resilience and production capacity

Strategic growth opportunities (M&A)

Accelerate strategy, innovation, pipeline, scale and capabilities. Lifecycle management

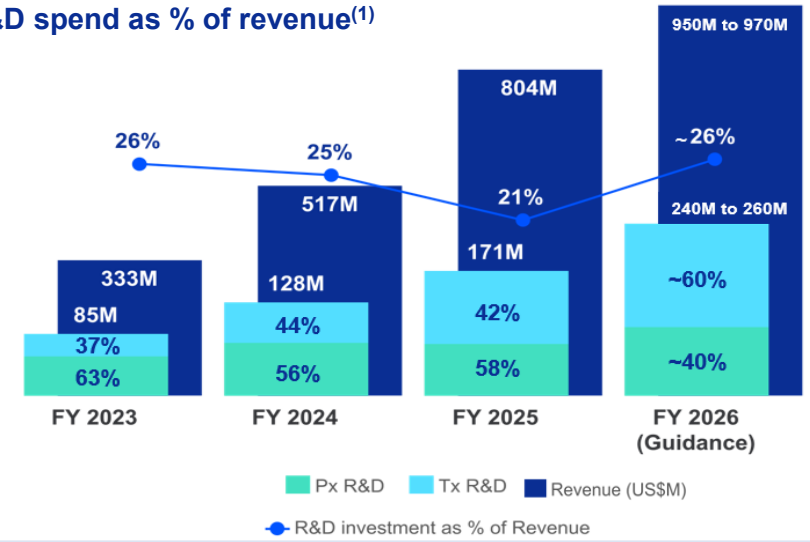
Capital prioritized for measurable milestones and high-value inflections

Telix

Disciplined R&D investment supported by commercial scale

R&D investment focused on late-stage assets

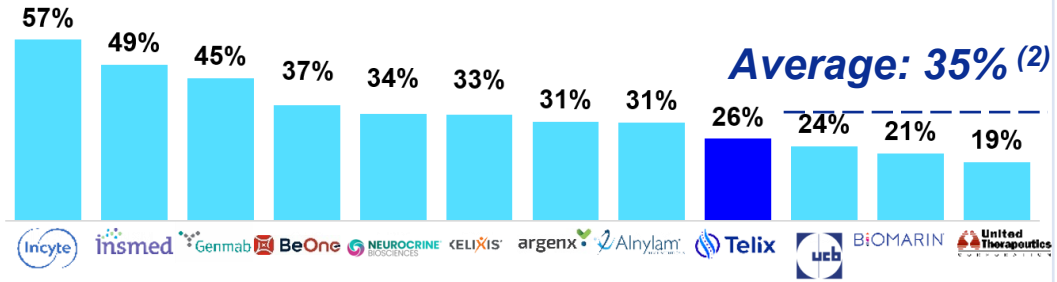
R&D spend as % of revenue(1)



- ✓ Focus capital on opportunities that can expand patient access and support long-term growth
- ✓ R&D investment tied to measurable milestones, clinical evidence and maximum value

Telix R&D investment below peer average

R&D as % of revenue(1)



- ✓ Commercial scale and pipeline progress achieved with R&D investment below therapeutics peers' average R&D spend 35%

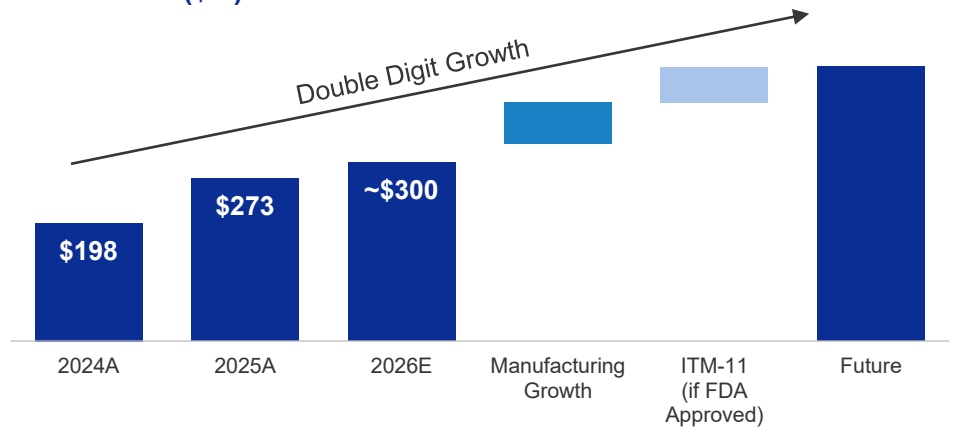
Telix

1. Refers to the midpoint of the revenue guidance of $950M - $970M for FY2026 and the midpoint of the R&D guidance of $240 - $260M, Telix ASX disclosure October 21, 2026.
2. Benchmarking source: Visible Alpha estimates, Wall Street Research. As of October 2026. Average excluding Telix.

ITM Combines Strong Revenue Growth with a Clear Path to Positive EBITDA

Strong Revenue Growth

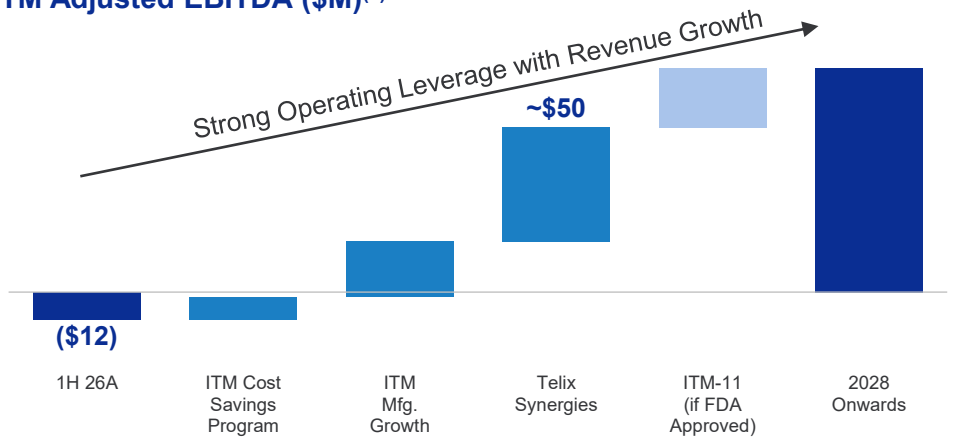
ITM Revenue ($M)[1]



- Expected double-digit growth in ITM manufacturing revenue
- Expected high-margin commercial therapeutic revenues if ITM-11 is approved by FDA

Attractive EBITDA Trajectory

ITM Adjusted EBITDA ($M)[1]



- Strong gross margin in manufacturing (>40%)
- ITM cost saving program well advanced
- Positive EBITDA contribution from 2027 onwards
- $50M targeted synergies in the first two years

1. ITM figures translated at an EUR / USD rate of 1.14. 2026E reflects expected ITM revenue for 2026. Telix ASX disclosure September 21, 2026.

The transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

Final remarks

Dr. Christian Behrenbruch
Managing Director
and Group CEO



Transformational period of growth

~US $1B
FY 2026E revenue and Other Income[1]

3
FDA approved imaging agents

22 countries
Illuccix available

4
Therapeutic candidates in late-stage trials[2]

Scaling our commercial business

Extending franchise leadership through product innovation, diversification and geographical expansion.

Building on commercial success of three FDA approved products.

Late-stage pipeline

Advancing late-stage diagnostic and therapeutic assets towards patient access.

Developing new targets and indications to fuel future growth.

Best-in-class manufacturing & supply

Expanding vertically integrated supply chain to support growth opportunities and extend competitive advantage – enabling growth at scale.

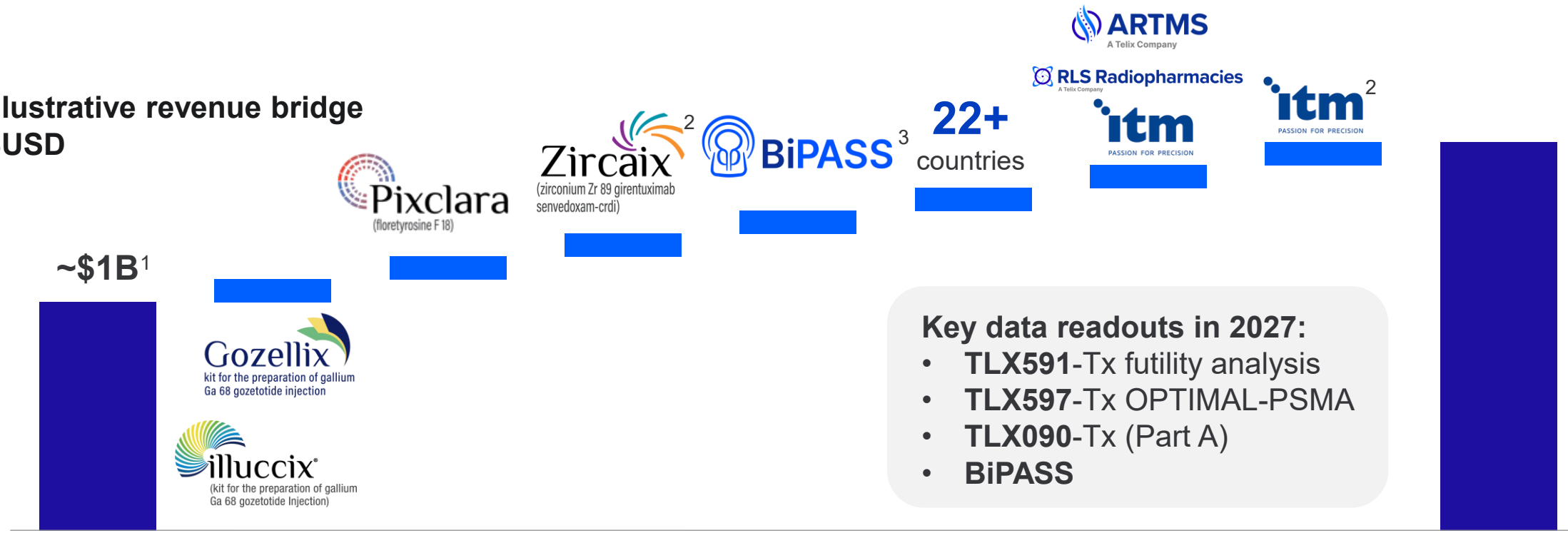
A global radiopharma powerhouse

Telix

1. Refers to revenue guidance of US $950M - $970M for FY2026 and $40M (Other Income), Telix ASX disclosure October 21, 2026.
2. Subject to close of transaction, the transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.

Multiple growth drivers building on a strong 2026 revenue base

Illustrative revenue bridge
$USD



Key data readouts in 2027:

- **TLX591**-Tx futility analysis
- **TLX597**-Tx OPTIMAL-PSMA
- **TLX090**-Tx (Part A)
- **BiPASS**

Note: Illustrative only; growth drivers shown equally weighted and not indicative of relative contribution. No FY 2027 guidance implied.
1 Refers to revenue guidance of $950M - $970M for FY2026 and $40M (Other Income), Telix ASX disclosure October 21, 2026.
2. Subject to regulatory approvals. ITM assets subject to close of transaction, the transaction with ITM is expected to close in FY2026 subject to Telix Shareholder approval, regulatory approvals, and other customary closing conditions.
3. Potential launch in late 2027 or 2028, subject to FDA approval.